Dr Premitha Damodaran v GTK (a child suing through her father and litigation representative, Taranjeet Singh a/l Bhagwan Singh) & Anor and another appeal

COURT OF APPEAL (PUTRAJAYA) — CIVIL APPEAL NOS W-02(NCVC)(W)-2006–11 OF 2019 AND W-02(NCVC)(W)-2018–11 OF 2019
YAACOB MD SAM, VAZEER ALAM AND GUNALAN MUNIANDY JJCA
23 DECEMBER 2021

Tort — Negligence — Medical negligence — Whether obstetrician negligently failed to advise pregnant mother of type of delivery suitable for her baby's size — Whether injuries mother and child suffered during delivery were caused by obstetrician's negligence — Whether obstetrician's management of second pregnancy and delivery was based on information mother had given about her first child's birth weight and mode of delivery — Whether mother and her husband gave obstetrician wrong information about their first child's birth weight — Whether obstetrician would have insisted on Caesarean section and not vaginal delivery if she had known of first child's real birth weight — Whether obstetrician had properly and ably handled baby's shoulder dystocia emergency during delivery — Whether care exercised by obstetrician in treating and managing mother before, during and after delivery was well within accepted medical standards

The two appeals herein emanated from a single judgment of the High Court which allowed the medical negligence claim of the infant first plaintiff ('GTK') and her mother, the second plaintiff ('Baljeet') against the first defendant ('Dr PD'), a consultant obstetrician and gynaecologist, but dismissed their claim against the second defendant, which owned and managed the Pantai Hospital Kuala Lumpur ('Pantai Hospital') where Dr PD had a practice. In Appeal No 2006, Dr PD sought to set aside the trial court's entire decision against her on liability and quantum while in Appeal No 2018, GTK and Baljeet appealed against the dismissal of their claim against the second defendant as well as the quantum of damages that was awarded against Dr PD. Having conceived GTK via in-vitro fertilisation, Baljeet consulted Dr PD and wanted her to manage her pregnancy, labour, delivery and post-natal care. GTK, who weighed 4.01kg at birth, was Baljeet's second child. When Baljeet was 39 weeks and five days' pregnant with GTK, Dr PD admitted her to Pantai Hospital for induction of labour and for the baby to be delivered vaginally as preferred by Baljeet. An emergency arose during the delivery when GTK's shoulder got stuck in the birth canal and Dr PD had to employ certain manoeuvres to free GTK and remove her from the canal as quickly as possible.

A In the process, GTK suffered brachial plexus injury to her left shoulder while Baljeet suffered a tear to her perineum. Both mother and daughter attributed their injuries to Dr PD's negligence and held the second defendant vicariously liable for Dr PD's acts and omissions. The medical evidence at the trial established that GTK's injury was not serious. In their suit, the plaintiffs B alleged, inter alia, that Dr PD did not discuss, explain or advise Baljeet and her husband about the risks and benefits of the modes of delivery that were available to her even though Baljeet had preferred a normal vaginal delivery rather than a Caesarean section. The plaintiffs also alleged that Dr PD failed to advise Baljeet and her husband that since GTK was a larger-than-normal baby C for her gestational age, the risk of her shoulder getting stuck in the birth canal (shoulder dystocia) during delivery was significantly higher. It was also alleged that when the dystocia occurred, Dr PD failed to execute the McRobert's manoeuvre correctly and had used excessive traction to free GTK which caused D the brachial plexus injury.

Held, unanimously allowing Appeal No 2006, dismissing Appeal No 2018 and setting aside the whole of the High Court's decision:

E (1) The circumstances of the instant case did not show how Dr PD had failed to discharge the standard of care that was required of her as an obstetrician. What she did to attend to the emergency during the delivery was well within accepted medical practice and the same was confirmed by her expert witness, Dr Mureli, an obstetrician and gynaecologist of many years standing. Hence, using the *Bolam* test, as modified by *Bolitho*, this F court found that the treatment and care of Baljeet during the delivery of the baby was well within 'practice accepted as proper by a responsible body of medical men skilled in that particular art'. There was thus no breach of the standard of care by Dr PD. The trial judge's finding to the contrary was plainly wrong (see para 93).

G (2) The trial judge had completely overlooked the inherent probabilities of the case in entering judgment for the plaintiffs. A careful perusal of the trial judge's grounds of judgment showed that the process of reasoning adopted by the judge for preferring the evidence of the plaintiffs' H witnesses was based upon a wrong premise and did not accord with well-established principles that went to form the fulcrum upon which the scales of justice turned. The trial judge's conclusion also went against the grain of evidence. This court was under a duty to intervene as the trial court had so fundamentally misdirected itself that one could safely say I that no reasonable court which had properly directed itself and asked the right questions would have arrived at the same conclusion (see para 103). *Ante-natal care*:

(3) There was ample evidence to support Dr PD's contention that she had discussed the option of a Caesarean section ('C-section') with Baljeet

even prior to the day Baljeet was admitted to Pantai Hospital for induction of labour. Baljeet's assertion that there was no discussion at all on that subject was negated by credible documentary and oral evidence. The contemporary documentary evidence showed that Dr PD had discussed the option of a C-section with Baljeet during the latter's ante-natal visits and there was also a Whatsapp text message on that subject between the two of them a day before Baljeet was admitted to the hospital for induction of labour. Dr PD's notes showed that Baljeet was not in favour of a C-section and preferred a normal vaginal delivery by induction. The trial judge misdirected herself and was plainly wrong when she concluded that Dr PD had never discussed or offered the option of a C-section delivery to Baljeet (see paras 31, 33 & 39–41).

(4) During Baljeet's first clinical consultation with Dr PD, the latter had recorded in her notes that the birth weight of Baljeet's first child ('S') was 4.54kg and that he was delivered vaginally. This was important to Dr PD as it helped her decide whether GTK, who was between 3.8kg and 4kg, could also have a normal vaginal delivery. Baljeet and her husband were adamant in their testimonies that they never told Dr PD that S's birth weight was 4.54kg but only that he was 'approximately 4kgs'. On this point, the trial judge preferred the evidence of Baljeet and her husband even though S's birth weight was stated to be 4.54kg in Dr PD's initial clinical notes, in Baljeet's insurance form, during the grievance meeting that was called by Pantai Hospital (which Baljeet, her husband and her father attended), in a medical report furnished by Dr PD to the plaintiffs' solicitors two years before the plaintiffs' action was filed, and in the reports of both the plaintiffs' and Dr PD's expert witnesses. If S's birth weight in all those instances was incorrect, it was never refuted or corrected at any time by Baljeet or her husband. It was only on the first day of the trial that the plaintiffs for the first time disclosed S's birth chart that documented his birth weight as 3.8kg. That 11th-hour disclosure necessitated an adjournment of the trial and the need for Dr PD to amend her defence (see paras 43–56).

(5) S's birth chart had always been in Baljeet's possession, but it was never shown to Dr PD or produced in the bundle of documents prior to the aborted first day of trial. The 11th-hour revelation of S's true weight caused Dr PD to amend her defence and subsequently testify at length that if she had known of S's true birth weight at the outset, her entire management of Baljeet would have been different and that she would have insisted on Baljeet undergoing a C-section and would not have agreed to a vaginal delivery given GTK's size. The uncontested documentary evidence and Baljeet's conduct leading up to the trial clearly showed that Baljeet had misinformed Dr PD of S's birth weight

right from the start, thus setting Dr PD on a path of management of Baljeet's pregnancy and delivery based on that misinformation (see paras 57–58).

(6) The trial judge erred and misdirected herself when she disregarded all these evidence, particularly the contemporaneous documentary evidence, and found that Dr PD had failed to prove on balance of probabilities that Baljeet and her husband had informed her that S's birth weight was 4.54kg based solely on the self-serving oral testimony of Baljeet and her husband. The trial judge failed to critically analyse and evaluate the plaintiffs' contemporaneous conduct in this regard. The judge ought to have tested Baljeet's and her husband's oral evidence against the entirety of the evidence and circumstances of the case to draw the appropriate inference and conclusion in order to ascertain where the overall probabilities lay. By merely accepting the evidence of Baljeet and her husband in contradiction to the evidence contained in the contemporaneous documents, there was insufficient judicial scrutiny and appreciation of the evidence by the trial judge. Given Dr PD's credentials and experience, it was highly improbable that a person of her calibre and experience would have just plucked a figure of 4.54kg out of thin air, and that too, down to two decimal points (see paras 58 & 60–61).

(7) Baljeet's failure to correct the recording of S's birth weight in the contemporary documents led to the irresistible conclusion that she had misinformed Dr PD about S's birth weight and then contrived to hide that fact when it became evident that S's actual birth weight was a crucial piece of information for Dr PD in her management of Baljeet's pregnancy and delivery. The trial judge's failure to apply the law correctly and to ask herself whether the version of the defence was consistent with the probabilities of the case had caused a miscarriage of justice that warranted appellate intervention (see paras 64–65).

(8) Dr PD was entirely justified in relying on the information given by Baljeet as part of her medical history including S's birth weight and the manner of his delivery, in formulating her treatment plan and advising on the delivery option. There was no breach of duty in this regard by Dr PD (see para 73).

(9) Dr PD's management of Baljeet was premised on the belief that if Baljeet had safely delivered her first 4.54kg baby normally, then so long as she took the necessary precautions to ensure that GTK's weight did not exceed 4kg, there was no appreciable or increased risk of shoulder dystocia. This was not only logical but was medically supported. Dr PD did precisely that based on the information that was given to her by Baljeet. In the circumstances, to blame Dr PD for not discussing a

possible C-section because of GTK's size was a wholly untenable, self-serving, post-delivery blame game which the trial judge ought to have rejected (see para 77).

(10) Dr PD could not be faulted for making a clinical judgment that GTK, who was estimated at between 3.8 to 4kg in weight, would not be at risk of shoulder dystocia or have presented an unusual risk to Baljeet such that Dr PD ought to have discussed and offered the C-section alternative to Baljeet (see para 79).

Management of labour and delivery:

(11) The evidence as a whole showed that the McRobert's manoeuvre was carried out when the dystocia occurred and that while the manouevre was being done, Dr PD used her hands to rotate the baby and in less than a minute the baby came out. This indicated that the McRobert's manoeuvre was a success and there was no need to apply suprapubic pressure which was only necessary if the McRobert's manoeuvre had failed. The trial judge's finding that Dr PD was negligent in not applying suprapubic pressure during the delivery was wrong as the situation did not warrant the application of that technique. There was also no evidential support for the plaintiffs' expert to opine that GTK's brachial plexus injury was caused by excessive traction (see paras 85 & 89–92).

(12) Shoulder dystocia was known to occur even in delivery of babies who were not macrosomic. During the antenatal visits, there was no indication that GTK would encounter shoulder dystocia for that topic to have been specifically dealt with by Dr PD and for Baljeet to be apprised of Dr PD's experience in handling such cases (see para 95).

Baljeet's injuries:

(13) Baljeet's tear to her perineum during the delivery was first attended to by Dr PD who had sutured it. Baljeet was later seen by Dr Kamaljit at the hospital who had examined her before discharge. There was no indication that there was anything wrong with the treatment that Baljeet had received from Dr PD for the injury to her perineum. The foul smell that came from that area some weeks later was attributed by Dr Hu Shan, as well as by the lactation consultant, Elizabeth Pithchaimuthu, to Baljeet's failure to maintain proper hygiene. To attribute blame to Dr PD was flawed as the causal link between the care and treatment given by Dr PD up to the point when Baljeet was discharged and the injury complained of much later had not been established. There was insufficient evidence to show that Baljeet's post-delivery injuries were not sufficiently identified, treated and managed by Dr PD. The evidence showed that it was more probable than not that the injuries identified and treated by Dr Hu Shan were exacerbated by Baljeet's poor hygiene in the affected parts coupled with her indifference to seeking treatment immediately

A when she was in pain and bleeding some two weeks after delivery, and not because of Dr PD's failure to properly identify and treat the injuries (see para 100).

[Bahasa Malaysia summary

B Ini adalah dua rayuan terhadap satu penghakiman Mahkamah Tinggi yang membenarkan tuntutan kecuaian perubatan bagi plaintif pertama bayi ('GTK') dan ibunya, plaintif kedua ('Baljeet') terhadap defendan pertama ('Dr PD'), seorang perunding obstetrik dan ginekologi, tetapi menolak C tuntutan mereka terhadap defendan kedua, yang memiliki dan menguruskan Hospital Pantai Kuala Lumpur ('Hospital Pantai') di mana Dr PD beramal. Di dalam Rayuan No 2006, Dr PD telah memfailkan rayuan untuk mengenepikan keseluruhan keputusan mahkamah perbicaraan atas liabiliti dan kuantum semasa dalam Rayuan No 2018, GTK dan Baljeet merayu D terhadap penolakan tuntutan mereka terhadap defendan kedua serta kuantum ganti rugi yang diberikan terhadap Dr PD. Setelah GTK dilahirkan secara persenyawaan in-vitro, Baljeet merujuk Dr PD untuk pengurusan kehamilan, bersalin, penghantaran dan penjagaan selepas bersalin. GTK, yang beratnya 4.01kg semasa lahir, adalah anak kedua Baljeet. Ketika Baljeet hamil 39 E minggu dan lima hari, Dr PD memasukkannya ke Hospital Pantai untuk induksi bersalin dan untuk bayi tersebut dilahirkan melalui faraj seperti yang diminta oleh Baljeet. Kecemasan timbul semasa kelahiran apabila bahu GTK tersekat di saluran kelahiran dan Dr PD terpaksa menggunakan manuver tertentu untuk mengeluarkan GTK secepat mungkin. Di dalam proses itu, F GTK mengalami kecederaan brachial plexus pada bahu kirinya manakala Baljeet mengalami koyakan pada perineumnya. Kedua-dua ibu dan anak perempuan mengaitkan kecederaan mereka dengan kecuaian Dr PD dan menganggap defendan kedua bertanggungjawab atas tindakan Dr PD. Keterangan perubatan ketika perbicaraan tersebut membuktikan bahawa G kecederaan GTK adalah tidak serius. Di dalam saman mereka, plaintif mendakwa, antara lain, bahawa Dr PD tidak membincangkan, menjelaskan atau menasihati Baljeet dan suaminya mengenai risiko mod kelahiran yang tersedia pada ketika itu walaupun Baljeet memilih kelahiran melalui faraj dari pembedahan Caesarean. Plaintif juga mendakwa bahawa Dr PD gagal H menasihati Baljeet dan suaminya bahawa disebabkan GTK adalah bayi yang lebih besar daripada biasa untuk usia kehamilannya, risiko bahunya tersangkut dalam saluran kelahiran (bahu *dystocia*) semasa bersalin jauh lebih tinggi. Mereka juga menghujahkan bahawa apabila *dystocia* berlaku, Dr PD gagal melaksanakan manoeuvre McRobert dengan betul dan telah menggunakan I tarikan yang berlebihan untuk mengeluarkan GTK yang akhirnya menyebabkan kecederaan plexus brachial.

Diputuskan, sebulat suara membenarkan Rayuan No 2006, menolak Rayuan No 2018 dan mengenepikan keseluruhan keputusan Mahkamah Tinggi:

(1) Keadaan kes ini tidak menunjukkan bagaimana Dr PD gagal untuk melaksanakan tugas berhati-hati yang diperlukan oleh beliau sebagai pakar obstetrik. Perkara yang dilakukan ketika proses kelahiran kecemasan tersebut adalah munasabah menurut amalan perubatan yang diterima dan diakui oleh saksi pakarnya, Dr Mureli, seorang pakar obstetrik dan ginekologi yang berpengalaman. Oleh itu, dengan menggunakan ujian *Bolam*, seperti yang ditambahbaik melalui kes *Bolitho*, mahkamah ini mendapati bahawa rawatan dan penjagaan Baljeet semasa melahirkan bayi tersebut merupakan 'amalan yang diterima sebagai munasabah di dalam bidang perubatan'. Oleh itu, tidak ada pelanggaran tugas berhati-hati oleh Dr PD. Dapatan hakim bicara adalah jelas merupakan satu kekhilafan (lihat perenggan 93).

(2) Hakim bicara telah mengabaikan kebarangkalian kes yang wujud ketika memberikan penghakiman yang memihak kepada plaintif. Penelitian terhadap alasan penghakiman hakim bicara menunjukkan bahawa haki bicara memilih keterangan saksi-saksi plaintif berdasarkan premis yang salah dan tidak sesuai dengan prinsip keadilan. Dapatan hakim bicara juga bertentangan dengan keterangan yang dikemukakan. Oleh yang demikian, perkara ini mewajarkan campur tangan mahkamah ini kerana hakim bicara telah terkhilaf kerana membuat dapatan tersebut (lihat perenggan 103).

Penjagaan ante-natal:

(3) Terdapat keterangan menyokong hujahan Dr PD bahawa dia telah memberikan pilihan kelahiran akan dilakukan secara pembedahan Caesarean ('C-section') kepada Baljeet sehari sebelum Baljeet dimasukkan ke Hospital Pantai untuk induksi bersalin. Hujahan Baljeet adalah tiada perbincangan adalah bercanggah dengan keterangan dokumentari dan keterangan lisan yang boleh dipercayai. Keterangan dokumentari menunjukkan bahawa Dr PD telah membincangkan pilihan *C-section* dengan Baljeet semasa lawatan *ante-natal* yang terakhir dan terdapat juga mesej teks Whatsapp mengenai perkara tesebut antara mereka berdua sehari sebelum Baljeet dimasukkan ke hospital untuk induksi bersalin. Nota Dr PD menunjukkan bahawa Baljeet tidak memilih kelahiran secara *C-section* dan memilih kelahiran melalui faraj. Hakim bicara adalah jelas terkhilaf salah arah apabila beliau membuat dapatan bahawa Dr PD tidak pernah membincangkan atau menawarkan pilihan kelahiran *C-section* kepada Baljeet (lihat perenggan 31, 33 & 39–41).

(4) Semasa konsultasi klinikal pertama Baljeet dengan Dr PD yang terakhir, berat kelahiran anak pertama Baljeet ('S') yang dicatatkan adalah 4.54kg dan bahawa dia dilahirkan melalui faraj. Ini penting bagi Dr PD kerana ianya membantu beliau memutuskan sama ada GTK, yang antara 3.8kg dan 4kg, juga boleh dilahirkan melalui faraj. Baljeet dan suaminya

menghujahkan bahawa mereka tidak pernah memberitahu Dr PD bahawa berat kelahiran S adalah 4.54kg tetapi hanya memberitahu 'kira-kira 4kg'. Hakim bicara lebih memihak kepada keterangan Baljeet dan suaminya walaupun berat kelahiran S dinyatakan 4.54kg di dalam nota klinikal awal Dr PD, di dalam borang insurans Baljeet, semasa mesyuarat oleh Hospital Pantai (yang Baljeet, suaminya dan bapanya hadir), di dalam laporan perubatan yang diberikan oleh Dr PD kepada peguam cara plaintif dua tahun sebelum tindakan plaintif difailkan dan dalam laporan kedua-dua saksi pakar plaintif dan Dr PD. Sekiranya berat kelahiran S dalam semua keadaan tersebut tidak betul, ianya tidak pernah disangkal atau diperbetulkan pada bila-bila masa oleh Baljeet atau suaminya. Hanya pada hari pertama perbicaraan bahawa plaintif buat kali pertama mendedahkan carta kelahiran S yang mendokumentasikan berat kelahirannya sebagai 3.8kg. Pendedahan secara tiba-tiba tersebut memerlukan penangguhan perbicaraan dan membuatkan Dr PD perlu memohon untuk meminda pembelaannya (lihat perenggan 43–56).

(5) Carta kelahiran S sentiasa berada di dalam simpanan Baljeet, tetapi ianya tidak pernah ditunjukkan kepada Dr PD atau diberikan dokumen sebelum hari pertama perbicaraan. Pendedahan secara tiba-tiba mengenai berat badan sebenar S menyebabkan Dr PD memohon untuk meminda pembelaannya dan seterusnya memberi keterangan bahawa sekiranya dia mengetahui berat kelahiran sebenar S pada awalnya, pengurusan kelahiran Baljeet akan berbeza dan semestinya beliau akan menasihati Baljeet menjalani *C-section* dan tidak akan bersetuju dengan kelahiran secara faraj menurut saiz badan GTK. Keterangan dokumentari tersebut yang tidak dipertikaikan dan tingkah laku Baljeet yang membawa kepada perbicaraan jelas menunjukkan bahawa Baljeet secara salahnya memberitahu Dr PD mengenai berat kelahiran S sejak awal, sehingga menyebabkan Dr PD melalukan proses kelahiran Baljeet berdasarkan maklumat yang salah (lihat perenggan 57–58).

(6) Hakim bicara telah terkhilaf arahnya ketika keterangan-keterangan ini tidak diteliti, terutamanya keterengan dokumentari dan memutuskan bahawa Dr PD telah gagal membuktikan melebihi imbangan kebarangkalian bahawa Baljeet dan suaminya telah memberitahunya bahawa berat lahir S adalah 4.54kg hanya berdasarkan keterangan lisan Baljeet dan suaminya. Hakim bicara telah terkhilaf ketika menilai tingkah laku plaintif-plaintif. Hakim bicara sepatutnya menguji keterangan lisan Baljeet dan suaminya terhadap keseluruhan keterangan dan keadaan kes tersebut melalui imbangan kebrangkalian. Dengan hanya menerima keterangan Baljeet dan suaminya yang bertentangan dengan keterangan dokumentari, hakim bicara telah terkhilaf. Memandangkan kelayakan dan pengalaman Dr PD, sangat mustahil bahawa seseorang yang berkaliber dan pengalamannya hanya menjangka

berat 4.54kg tersebut dan lebih-lebih lagi dua titik perpuluhan (lihat perenggan 58 & 60–61).

(7) Kegagalan Baljeet untuk membetulkan rekod berat kelahiran S di dalam dokumen tersebut membawa kepada kesimpulan yang tidak dapat dinafikan bahawa dia telah salah memberitahu Dr PD mengenai berat kelahiran S dan kemudiannya menyembunyikan fakta tersebut. Dia mengetahui bahawa berat lahir sebenar S adalah maklumat penting bagi Dr PD di dalam pengurusan kehamilan dan kelahiran Baljeet. Kegagalan hakim bicara untuk mengaplikasikan undang-undang dengan betul dan meneliti sama ada versi pembelaan tersebut konsisten dengan kebarangkalian kes tersebut telah menyebabkan penafian keadilan yang memerlukan campur tangan rayuan ini (lihat perenggan 64–65).

(8) Dr PD sepenuhnya bergantung pada maklumat yang diberikan oleh Baljeet sebagai sebahagian daripada proses perubatannya termasuk berat lahir S dan kaedah kelahirannya, termasuk rancangan rawatannya dan memberi nasihat mengenai pilihan kaedah kelahiran. Tiada pelanggaran tugas berhati-hari di dalam hal ini oleh Dr PD (lihat perenggan 73).

(9) Pengurusan Dr PD Baljeet berdasarkan kepercayaan bahawa sekiranya Baljeet telah selamat melahirkan bayi pertamanya yang mempunyai berat sebanyak 4.54kg secara normal, oleh yang demikian selagi beliau mengambil langkah berjaga-jaga yang diperlukan untuk memastikan bahawa berat Badan GTK tidak melebihi 4kg, tidak ada risiko *dystocia* bahu. Hal ini bukan sahaja masuk akal tetapi disokong secara perubatan. Dr PD melakukannya dengan tepat berdasarkan maklumat yang diberikan kepadanya oleh Baljeet. Dalam keadaan ini, untuk menyalahkan Dr PD kerana tidak membincangkan kemungkinan *C-section* kerana saiz GTK adalah tidak dapat dipertahankan, mementingkan diri, dan merupakan perbuatan menyalahkan orang lain yang sepatutnya diambil kira oleh hakim bicara (lihat perenggan 77).

(10) Dr PD tidak boleh dipersalahkan kerana membuat penilaian klinikal bahawa GTK, yang dianggarkan antara 3.8 hingga 4kg berat badan, tidak akan berisiko *dystocia* bahu atau mempunyai risiko lain yang luar biasa kepada Baljeet sehingga Dr PD sepatutnya membincangkan dan menawarkan alternatif *C-section* kepada Baljeet (lihat perenggan 79).

Pengurusan kandungan dan kelahiran:

(11) Keterangan secara keseluruhan menunjukkan bahawa kaedah McRobert telah dijalankan apabila *dystocia* berlaku dan semasa kaedah tersebut sedang dilakukan, Dr PD menggunakan tangannya untuk memutar bayi dan dalam masa kurang dari satu minit bayi tersebut keluar. Ini menunjukkan bahawa kaedah McRobert berjaya dan tidak perlu menggunakan tekanan suprapubic yang hanya perlu jika kaedah McRobert gagal. Penemuan hakim bicara bahawa Dr PD cuai kerana

tidak menggunakan tekanan suprapubik semasa penghantaran adalah salah kerana keadaan tersebut tidak memerlukan penggunaan teknik tersebut. Tiada keterangan pakar plaintif bahawa kecederaan plexus brachial GTK disebabkan oleh daya tarikan yang berlebihan (lihat perenggan 85 & 89–92).

(12) *Dystocia* bahu secara umumnya berlaku berlaku walaupun di dalam kelahiran bayi yang tidak makrosomik. Semasa rawatan antenatal, tiada petunjuk bahawa GTK akan menghadapi *dystocia* bahu dan ianya telah ditangani secara khusus oleh Dr PD dan Baljeet mengetahui Dr PD berpengalaman di dalam mengendalikan kes-kes seperti itu (lihat perenggan 95).

Kecederaan Baljeet:

(13) Kecederaan perineum Baljeet semasa kelahiran pertama kali telah dijahit oleh Dr PD. Baljeet kemudiannya dirawat oleh Dr Kamaljit di hospital yang telah memeriksanya sebelum keluar. Rawatan Baljeet oleh Dr PD tersebut untuk kecederaan perineumnya. Bau busuk yang datang dari kawasan tersebut beberapa minggu kemudiannya dikaitkan oleh Dr Hu Shan, dan juga oleh konsultan laktasi, Elizabeth Pithchaimuthu, yang merujuk kepada kegagalan Baljeet untuk merawat secara bersih dan betul. Untuk mengaitkan kesalahan kepada Dr PD adalah tidak munasabah kerana hubungan kausal antara penjagaan dan rawatan yang diberikan oleh Dr PD sehingga ketika Baljeet selesai rawatan dan kecederaannya belum diwujudkan pada ketika itu. Keterangan yang dikemukakan adalah tidak mencukupi untuk menunjukkan bahawa terdapat kecederaan selepas bersalin yang mana diuruskan oleh Dr PD. Keterangan menunjukkan bahawa kecederaan tersebut dan dirawat oleh Dr Hu Shan disebabkan oleh kegagalan Baljeet untuk memastikan kebersihan di bahagian tersebut dan tindakan Baljeet yang gagal mendapatkan rawatan dengan segera ketika dalam kesakitan dan pendarahan kira-kiradua minggu selepas bersalin, dan bukannya kerana kegagalan Dr PD membuat rawatan yang sepatutnya (lihat perenggan 100).]

Cases referred to

Armagas Ltd v Mundogas SA; The Ocean Frost [1985] 3 All ER 795; [1985] 1 Lloyd Rep 1, CA (refd)

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118; [1957] 1 WLR 582, QBD (refd)

Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, HL (refd)

Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45; [1967] 1 LNS 25, PC (refd)

Eastern & Oriental Hotel (1951) Sdn Bhd v Ellarious George Fernandez & Anor [1989] 1 MLJ 35, SC (refd)

Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171; [1960] 1 LNS 24 (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229, FC (refd)
Gan Yook Chin (P) & Anor v Lee Ing Chin @ Lee Teck Seng & Ors [2005] 2 MLJ 1; [2004] 4 CLJ 309, FC (refd)
Guan Teik Sdn Bhd v Haji Mohd Noor bin Haji Yakob & Ors [2000] 4 MLJ 433; [2000] 4 CLJ 324, CA (refd)
Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128; [1981] 1 LNS 208, FC (refd)
Lee Ing Chin @ Lee Teck Seng & Ors v Gan Yook Chin & Anor [2003] 2 MLJ 97; [2003] 2 CLJ 19, CA (refd)
Len Min Kong v United Malayan Banking Corp Bhd and another appeal [1998] 2 MLJ 478; [1998] 2 CLJ 879, CA (refd)
Majlis Perbandaran Seremban v Era Baru Sdn Bhd and another appeal [2018] MLJU 706; [2018] 1 LNS 829, CA (refd)
Ming Holdings (M) Sdn Bhd v Tuan Syed Azahari bin Noh Shahabudin & Anor [2010] 4 MLJ 577; [2010] 6 CLJ 857, FC (refd)
Onassis and Calogeropoulos v Vergottis [1968] 2 Lloyds Report 403 (refd)
Rogers v Whitaker (1992) 175 CLR 479, HC (refd)
Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, HL (refd)
Sivalingam a/l Periasamy v Periasamy & Anor [1995] 3 MLJ 395; [1996] 4 CLJ 545, CA (refd)
Theow Say Kow @ Teoh Kiang Seng, Henry v Graceful Frontier Sdn Bhd & Ors and other appeals [2020] MLJU 57; [2020] 1 LNS 52, CA (refd)
Tindok Besar Estate Sdn Bhd v Tinjar Co [1979] 2 MLJ 229; [1979] 1 LNS 119, FC (refd)
Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438; [2017] 8 CLJ 605, FC (refd)

Appeal from: Suit No 22NCVC-655–12 of 2015 (High Court, Kuala Lumpur)

Sreether Sundaram (Narandra Kangatharan and Vhimall Murugesan with him) (Murali B Pillai and Assoc) for the appellant.
MS Dhillon (Desmond Mun, Jeremy and KB Karthi with him) (PS Ranjan & Co); Felix Raj (Ahmad Aizek Busu with him) (Felix Raj Chambers) for the respondent.

Vazeer Alam JCA (delivering judgment of the court):

INTRODUCTION

[1] The two appeals before us emanate from a single judgment of the High Court where the first plaintiff ('GTK'), an infant, and her mother the second plaintiff ('Mdm Baljeet'), succeeded partially in their medical negligence claim against the first defendant ('Dr Premitha') a consultant obstetrician and gynaecologist, but failed in their claim against the second defendant, the company that owns and manages the Pantai Hospital Kuala Lumpur ('Pantai Hospital').

[2] The first appeal, ie Civil Appeal No W-02(NCVC)(W)-2006–11 of 2019, by the first defendant (Dr Premitha) is against the entirety of the High Court's judgment, ie both in respect of liability and quantum. The second appeal, ie Civil Appeal No W-02(NCVC)(W)-2018–11 of 2019, by the first and second plaintiffs is against firstly, the dismissal of their respective claims against the second defendant, and secondly in respect of the quantum of damages awarded against the first defendant.

BACKGROUND FACTS

[3] The first defendant, a consultant obstetrician and gynaecologist had a medical practice at Pantai Hospital. The second plaintiff, Mdm Baljeet, who was then pregnant with her second child, conceived via in vitro-fertilisation ('IVF'), consulted the first defendant as a patient. Mdm Baljeet had personally chosen the first defendant based on her fertility doctor's (Dr Prashant) advice.

[4] Mdm Baljeet testified that her second pregnancy was a precious pregnancy as the baby was conceived after two IVF treatments. During her first three months of pregnancy, Mdm Baljeet was under the professional care of Dr Prashant, who then referred her to the first defendant. Dr Premitha, as Mdm Baljeet's consultant obstetrician and gynaecologist, was responsible for Mdm Baljeet's care during her pregnancy, labour, delivery and post-natal care.

[5] At 39 weeks five days gestation, Mdm Baljeet following Dr Premitha's advice was admitted into Pantai Hospital for induction of labour. On 14 May 2015, Mdm Baljeet gave birth to GTK. As a result of complications during delivery, GTK suffered brachial plexus injury to her left shoulder and Mdm Baljeet suffered a tear to her perineum.

[6] The plaintiffs attribute the injuries suffered to the professional negligence of Dr Premitha. The plaintiffs' case of negligence against the first defendant is premised on lack of documentation, failure to give adequate

advice, information and/or warning, failure to take proper informed consent, failure to perform a complete and accurate McRoberts manoeuvre during delivery, and using excessive force in handling the delivery.

[7] The plaintiffs claimed that both the first and second defendants, and each of them, owed independent duties of care to the plaintiffs. They also claimed that the second defendant, Pantai Hospital, owed them a non-delegable duty of care and that they were vicariously liable for the first defendant's wrongful acts and omissions.

[8] The salient facts of the case are well set out in the judgment of the learned High Court judge, and we reproduce them:

> Material Facts
>
> [18] Mdm Baljeet's pregnancy, which is the subject-matter of these proceedings, was her second pregnancy. Her first pregnancy was in 2003. She had delivered her eldest son STS ('S') on 26 October 2013. The delivery was undertaken by Dr Gunasegaran at the Damansara Specialist Hospital at 42 weeks after an induction and subsequent vacuum delivery.
>
> [19] GTK was conceived by in-vitro fertilisation ('IVF') from a frozen embryo transfer. Mdm Baljeet testified that this second pregnancy was a precious pregnancy as the baby was conceived after two IVF attempts — the first being unsuccessful. During the first three months of her pregnancy, Mdm Baljeet was under the professional care of Dr Prashant of the KL Fertility Centre. She was then referred by Dr Prashant to D1. Mdm Baljeet said that her choice of D1 was because of Dr Prashant's recommendation.
>
> [20] Mdm Baljit first consulted D1 on 20 November 2013 and again on 12 December 2013, 7 January 2014, 7 February 2014, 8 March 2014, 27 March 2014, 11 April 2014, 22 April 2014, 30 April 2014, 7 May 2014 and 12 May 2014. The records show that her blood pressure was within normal limits and that uterine growth, assessed by physical examination and ultrasound, was compatible with her dates. During the consultation on 7 May 2014, at 38+ weeks gestation, D1 noted in her medical records that Mdm Baljeet was 'not keen to prolong pregnancy till past dates' and was 'keen on induction'. D1 informed Mdm Baljeet that she will be away from 16–19 May 2014. Her notes on 7 May 2014 states 'Informed I am not around from 16/5-19/5'.
>
> [21] On 12 May 2014, at 39 weeks four days gestation, Mdm Baljeet consulted D1 and informed her that she had diarrhoea and had vomited overnight. On examination, Mdm Baljeet was found to be dehydrated. Her blood pressure was 127/72 mm Hg and her weight was 92.5kg. Vaginal examination findings were the same as during the previous consultation. The estimated foetal weight was 3.8–4kg. D1's notes state that there was a discussion about induction or waiting until 41 weeks gestation. She noted 'induction as Cx still unfavourable. — Needs overnight Prostin, then Syntocinon. If still fails, for LSCS (not keen). Want to try normal. Leave alone — await labour or induce at 41/52. Prefers induction with Prostin. Admit 13 May 14 for Prostin'. According to the ultrasound report, the estimated

foetal weight was 3.753 plus/minus 0.548kg and 3.649 plus/minus 0.533kg.

[22] On 13 May 2014, at 39 weeks five days gestation, Mdm Baljeet was admitted into Pantai Hospital KL at 2215 hours for induction of labour. D1 documented 'big baby' at 40 weeks. She examined Mdm Baljeet at 2240 hours.

[23] On 14 May 2014, at 0800 hours, Mdm Baljeet received an epidural by Dato Dr Damodaran. At 0830 hours, her membranes were artificially ruptured. Mdm Baljeet was nursed in the left lateral position and was given intravenous Hartmann's solution. At 1020 hours, D1 saw Mdm Baljeet and instructed the nurses that Oxytocin could be started after 15 minutes. At 1045 hours, Oxytocin was commenced. Mdm Baljeet was recorded as having one mild contraction every 5–6 minutes. At 1430, D1 conducted a vaginal examination on Mdm Baljeet, which revealed a cervical dilatation of 7cm. She was then catheterised and informed that there was 'good progress'. At 1535 hours, Mdm Baljeet requested for an epidural 'top-up' as the contractions were getting more frequent. Dato Dr Damodaran saw her again and prescribed Naropin.

[24] On 14 May 2014 at 1745 hours, D1 examined Mdm Baljeet again and note that she was fully dilated and was asked to commence 'pushing'.

[25] GTK was delivered on 14 May 2014 at 1825 hours at 39 weeks six days gestation by way of a Neville Barnes forceps delivery. After her birth, she was diagnosed as having Erb's palsy. She suffered brachial plexus injuries to her left arm. Mdm Baljeet suffered a second-degree tear to her perineum, which was later repaired by Dr Hu Shan (SP2) by way of an operation.

THE LATEST MEDICAL REPORT ON GTK

[9] Before we delve into the issues raised in the appeals, it would be worth noting that Dato Dr Sivanathan Shanmugam (SD9) ('Dr Sivanathan'), the first defendant's expert witness, testified that GTK's birth injury did not cause any permanent disability to the left upper limb and that she did not have any scoliosis. He further stated that the chances of GTK developing scoliosis in the future was the same as any normal girl in her age group. Dr Sivanathan also confirmed that the birth injury will not cause any deformity in her spine or shoulder in the future. This opinion is also found in Dr Sivanathan's medical report dated 4 May 2019, which was done following an examination on GTK after the close of trial and before the trial court delivered judgment. This report was tendered as evidence after the plaintiffs' counsel had applied for leave of court to reopen the trial on grounds that GTK's parents were informed by her physiotherapist that GTK had developed mild scoliosis. Scoliosis is a sideways curvature of the spine. The plaintiffs sought to attribute this to the injuries that GTK suffered from complication during birth. GTK was at this point examined by both Dr Sivanathan and the plaintiff's expert Dr Kavitha Uma Ratnalingam ('Dr Kavitha').

[10] The learned trial judge had addressed this issue in her grounds of

judgment as follows:

[218] After the trial had concluded and parties had made their submissions, counsel for the plaintiffs asked for leave to reopen the trial for the testimony of the plaintiffs' and D1's experts because after the trial, GTK's parents were told by her physiotherapist that GTK had developed mild scoliosis.

[219] This court allowed the application. The plaintiffs' expert was Dr Kavitha Uma Ratnalingam (SP6), who is consultant rehabilitation physician who had testified earlier in the trial and the D1's expert was Datuk Dr Sivananthan Shanmugam (SD9), who is a consultant trauma orthopedic surgeon.

[220] During the re-opened trial, learned counsel for the plaintiffs, Mr MS Dhillon said that the Court of Appeal had previously in 'Muthu's case' (Suit No N-04-W-213–05 of 2018) rejected Dr Sivananthan's expert testimony. However, upon reviewing the transcript of the proceedings in the said appeal, it is clear that the Court of Appeal did not reject Dr Sivananthan's testimony. Learned counsel also told Dr Sivananthan that he had criticised other defence experts in other cases for failing to write down the Mallet score. Mr Dhillon informed this court that he will be providing notes of evidence in the 'Penang' case to 'confront' Dr Sivananthan with. However, up to the date, this court delivered its decision, learned counsel did not provide this court with the notes of evidence in the 'Penang case'.

[221] As the allegations by plaintiffs' counsel against Dr Sivananthan in 'Muthu's case' proved to be without basis and there were no notes of evidence substantiating the allegations in the 'Penang case', I decided to ignore them. In doing so, I advised counsel not to make aspersions on the character of an expert witness, particularly when there is no evidence to substantiate such aspersions.

[222] Dr Kavitha concluded that GTK has functional scoliosis as opposed to structural scoliosis. When asked by this court of the difference between functional scoliosis and structural scoliosis, Dr Kavitha explained that functional scoliosis means that there is no need to treat the spine and that the spine can be corrected by correcting her posture and strengthening the weak muscles; whereas with structural scoliosis, surgery to the spine is required to correct the spine. Dr Kavitha concluded that no surgical intervention is required to correct the functional scoliosis. It requires the strengthening of her left shoulder muscles.

[223] Dr Kavitha's clinical findings contradicted with what was shown on the X-Ray of GTK's spine. She had stated that there is mild curve of GTK's spine, convex to the right. However, Dr Sivanathan testified that looking at the X-Ray the spine was convex to the left. He demonstrated during the trial with the original X-Ray film, a light box and a ruler that GTK's spine was shown to convex to the left. During the trial, Dr Kavitha confirmed that she agreed with Dr Sivanathan that looking at the X-Ray, the spine is indeed convex to the left. She explained that her earlier erroneous finding was based on what was stated by the radiologist.

[224] *According to Dr Sivananthan, GTK does not have scoliosis presently and that her chances of developing scoliosis in the future is that of any normal girl in her age group. I find that Dr Sivananthan's expert opinion to be reasonable, responsible, respectable and stands up to logical analysis.*

> [225] Although Dr Kavitha is of the opinion that GTK has functional scoliosis and Dr Sivananthan is of the opinion that GTK does not have scoliosis, both experts are in agreement that GTK does not need any corrective surgery to her spine in the future. They were both of the opinion that GTK would only need physiotherapy and exercise to strengthen her left shoulder muscles. (Emphasis added.)

[11] Though there were some differences of opinion between Dr Sivanathan and Dr Kavitha, the learned trial judge ultimately chose the opinion of Dr Sivanathan for reasons found in the above passages. This puts into perspective the nature of GTK's injury arising from her birth complications. What was initially stated to be serious and permanent lifelong injuries were in fact not that serious according to the latest available medical opinion.

DELIVERY OF GTK

[12] The evidence shows that the second plaintiff preferred a normal delivery, which was attempted after careful consideration by Dr Premitha and discussion with Mdm Baljeet. However, due to the inability of the second plaintiff to deliver normally during labour, forceps were used by the first defendant. With the instrument delivery the baby's head was delivered with one pull. However, the umbilical cord was wound around the baby's neck. The umbilical cord was cut and separated by the first defendant. At this juncture, there was no further descent and the baby's shoulders were stuck in a transverse lie. According to the first defendant, McRoberts manoeuvre was initiated and the first defendant rotated the stuck baby by using her hands and managed to deliver her. The baby weighed 4.01kg with an Apgar score of 8/9. The baby had suffered brachial plexus injury to her left shoulder. The second plaintiff had a first degree fourchette tear that was sutured in two layers by the first defendant. Haematosis was achieved and Volteran suppositories were inserted for pain relief. A few days later the second plaintiff was discharged after having been seen and attended to by Dr Kamaljit, an obstetrician and gynaecologist, standing in for the first defendant who was on leave attending a medical conference.

THE LAW ON MEDICAL NEGLIGENCE

[13] The Federal Court in *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128; [1981] 1 LNS 208 speaking through Salleh Abbas FCJ (as he then was) observed:

> A doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, ie the skill of an ordinarily competent medical practitioner (*R v Bateman* [1925] All ER 45).

Now, what was that reasonable standard of care and skill that the medical

professional owed his patient? In Malaysia, the *Bolam* test on the standard of care was the applicable law in medical negligence until the decision of the Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 (FC) ('Foo Fio Na').

[14] The *Bolam* test was formulated by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582, where the learned judge made the following remarks on the standard of proof in a medical negligence suit:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

And on the duty and standard of care of a doctor vis a vis a patient, McNair J made this pronouncement:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[15] The *Bolam* test simply meant that while the law imposed a duty of care, the standard of care owed by a doctor to a patient is left to the medical fraternity ie, the 'practice accepted as proper by a responsible body of medical men skilled in that particular art'. In other words, for all intends and purposes the medical practitioners had the final say as to whether there was negligence and not the courts. This was reaffirmed by the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, where Lord Scarman held:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.

[16] The *Bolam* test was applied by Raja Azlan Shah J (as HRH then was) in *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171; [1960] 1 LNS 24, in the following terms:

> The principle of law is well established that a practitioner cannot be held negligent if he treads the well-worn path; he cannot be held negligent if he follows what is the general and approved practice in the situation with which he is faced. There is the

judgment of the Privy Council in *Vancouver General Hospital v MacDaniel & Anor* [1934] 152 LJ 56 for such a proposition. I might also refer to a statement which is contained in a Scottish case, *Hunter v Harley* [1955] SLT 213 at p 217 where the Lord President (Lord Clyde) said this:

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men ... The true test for establishing negligence in diagnosis or treatment on the part of a doctor whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of it acting with ordinary care.

McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at p 122 put the matter in this way:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

I think that disposes of this matter.

[17] Subsequently, the Privy Council in *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45; [1967] 1 LNS 25 had in allowing an appeal from Malaysia reaffirmed the application of the *Bolam* test in a claim for medical negligence, where Sir Hugh Wooding stated:

> It was not in dispute that before prescribing or authorising the injection to be given Dr Devadason did not inquire into the deceased's medical history. On the contrary, he frankly admitted this himself. So the sole question which Ong J had to determine was whether any duty lay on the doctor to make such inquiry. For this purpose he adopted the test, in their lordships' opinion quite rightly, which was propounded by McNair J in *Bolam v Friern Hospital Management Committee* ...

The application of the *Bolam* test in Malaysia is well rooted and in essence the principle did not permit the court to find the doctor negligent in preference to one body of distinguished professional opinion to another.

[18] Then in *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151 Lord Browne-Wilkinson observed that 'in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold the body of opinion is not reasonable or responsible' and thus reject that body of opinion. In this regard, Lord Browne-Wilkinson stated:

> My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who

> are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice ... The use of these adjectives -responsible, reasonable and respectable — all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.
>
> ...
>
> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence.

[19] Hence, the qualification to the *Bolam* test made by *Bolitho* was that, if the body of medical opinion does not withstand logical analysis, the court may hold that such opinion is not reasonable or responsible and may then depart from it. In effect, *Bolitho* retained the *Bolam* test for all purposes in respect of medical negligence, but made it subject to the condition that for the expert opinion to be acceptable to the courts, it must be capable of withstanding logical analysis and reason.

[20] The *Bolam* test as modified by *Bolitho* has been applied by the Malaysian courts for some time now, and that was the state of the law until the Federal Court decision in *Foo Fio Na*, which followed the Australian High Court decision in *Rogers v Whitaker* (1992) 175 CLR 479 ('Rogers v Whitaker'). The High Court of Australia in *Rogers v Whitaker* took the view that the standard of care and factors to determine whether there was a breach of duty vary according to whether it involves diagnosis, treatment or provision of

information or advise, and in that regard held that:

> The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty. However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors ...
>
> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended.
>
> Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment.

The Australian High Court then concluded:

> The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.

[21] The Federal Court in *Foo Fia Na* adopted the test set out in *Rogers v Whitaker* and held:

> [39] ... we are of the opinion that the *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed

> treatment with knowledge of the risks involved or decline to be subjected to such treatment.
>
> [78] ... there is a need for members of the medical profession to stand up to the wrongdoings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium then [sic] the *Bolam* test ...

[22] Following *Foo Fio Na*, there arose two inconsistent lines of decisions by our courts on the standard of care in medical negligence. On one hand, there were decisions of the High Court and the Court of Appeal where it was held that the *Bolam* test no longer applied and that it was now for the courts to decide whether there has been a breach of the standard of care by a medical practitioner. On the other hand, there were decisions of the High Court and Court of Appeal which emphasised that the test in *Foo Fio Na* and *Rogers v Whitaker* relates only to a medical practitioner's duty to advise or provide information to a patient and this does not apply to the standard of care that is expected from a medical practitioner in respect of the duty to diagnose and to treat.

[23] This anomalous situation was put to rest by the Federal Court in *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438; [2017] 8 CLJ 605 where it was held that the test in *Rogers v Whitaker,* followed by *Foo Fio Na,* in regard to the standard of care in medical negligence is restricted only to the duty to advise the risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applied, subject to the qualifications in *Bolitho*. The Federal Court was of the view that in 'respect of the standard of care in medical negligence cases, a distinction must be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other. This is because diagnosis and treatment are purely in the realm of medicine and in the field of medicine, there are genuine differences of professional opinion in respect of diagnosis and treatment'.

[24] With that, the law as to the standard of care in medical negligence cases in Malaysia was well settled. We shall now move on to consider the issues raised in the two appeals.

THE LAW ON APPELLATE INTERVENTION

[25] We are mindful of our limited role as an appellate court in relation to findings of facts made by the court of first instance, and in this regard we are

reminded of the pronouncement of this court in *Lee Ing Chin @ Lee Teck Seng & Ors v Gan Yook Chin & Anor* [2003] 2 MLJ 97; [2003] 2 CLJ 19 to the following effect:

> ... an appellate court will not, generally speaking, intervene unless the trial court is shown to be plainly wrong in arriving at its decision. But appellate interference will take place in cases where there has been no or insufficient judicial appreciation of the evidence.

The Federal Court in *Gan Yook Chin (P) & Anor v Lee Ing Chin @ Lee Teck Seng & Ors* [2005] 2 MLJ 1; [2004] 4 CLJ 309 clarified that the test of 'insufficient judicial appreciation of evidence' adopted by the Court of Appeal was in relation to the process of determining whether or not the trial court had arrived at its decision or findings correctly on the basis of the relevant law and the established evidence.

[26] The Federal Court in *Ming Holdings (M) Sdn Bhd v Tuan Syed Azahari bin Noh Shahabudin & Anor* [2010] 4 MLJ 577; [2010] 6 CLJ 857 reaffirmed the principle of appellate intervention, and it is now trite that specific finding of facts by the trial judge as a trier of facts should not be disturbed by an appellate court unless that finding was plainly wrong. There could also be appellate intervention when there is insufficient judicial appreciation of evidence, such that the inferences and conclusions drawn by the learned trial judge is unsupported by the evidence or is simply untenable in law.

The first appeal

[27] The plaintiffs' claim against the first defendant is summarised in paras 29–31 of the grounds of judgment:

> [29] The plaintiffs advanced two distinct grounds of negligence against D1 they relate to: (i) Mdm Baljeet's antenatal care; and (ii) the management of Mdm Baljeet's labour and GTK's delivery.
>
> [30] The particulars of D1's negligence pleaded by the plaintiffs are as follows:
>
> (a) antenatal care:
>
> (i) D1 failed to discuss with Mdm Baljeet and her husband and provide them with sufficient advice on the risks and benefits of all delivery options so as to allow Mdm Baljeet and her husband to make an informed decision on the delivery options;
>
> (ii) when Mdm Baljeet expressed a desire to attempt a vaginal delivery and was not keen on a caesarean delivery, D1 failed to discuss, explain and advise Mdm Baljeet and her husband of the risks and benefits of the various delivery options. Instead D1 encouraged Mdm Baljeet to undergo vaginal delivery;

(iii) D1 failed to advise Mdm Baljeet and husband that GTK in utero was at higher risk of becoming macrosomic baby; and

(iv) D1 failed to advise Mdm Baljeet and her husband that macrosomia was a reliable predictor of shoulder dystocia and was likely to occur in this case.

(b) management of labour and delivery:

(c) D1 undertook insufficient monitoring of the labour after having induced the labour;

(d) D1 failed to anticipate the material risk of shoulder dystocia occurring;

(e) D1 failed to have sufficient and adequate obstetric assistants or nurses available to assist when the shoulder dystocia occurred in baby GTK;

(f) D1 failed to execute the McRobert's manoeuvre correctly and accurately;

(g) D1 undertook the McRobert's procedure with insufficient assistance from the obstetric team;

(h) D1 applied excessive traction to free baby GTK's shoulder during her delivery which caused the brachial plexus injury;

(i) D1 failed to call, without delay, for appropriate assistance when the shoulder dystocia occurred; and

(j) D1 failed to have the correct set of forceps when undertaking the delivery.

[31] The plaintiffs contend that GTK's birth was complicated by the shoulder dystocia emergency. Also, following a failed attempt in properly executing a McRoberts manoeuvre, D1 had used excessive and unjustifiable traction in delivering GTK causing injuries to both plaintiffs.

Issues raised in the first appeal

[28] The learned trial judge identified the issues at trial as follows:

[26] In summary, the main issues raised by the plaintiffs against D1 are as follows:

(a) whether D1 had a duty to advise Mdm Baljeet on her delivery options?

(b) whether D1 should have advised Mdm Baljeet on the risks and benefits of a caesarean section as opposed to a vaginal delivery;

(c) whether D1 should have disclosed to Mdm Baljeet that she had insufficient experience in managing shoulder dystocia cases;

(d) whether D1 should have suspected the possibility of a shoulder dystocia complication;

(e) whether D1 had undertaken correct management of the shoulder dystocia complication;

(f) whether D1 should have contacted Dr Gunasegaran so as to get details of S's birth and weight; and

(g) whether Mdm Baljeet's perineal and vaginal injuries had been sufficiently identified, treated and managed?

[27] The plaintiffs' claim against D2 are as follows:

(a) D2 is vicariously liable for any negligence of D1;

(b) D2 is vicariously liable for its nurses and agents; and

(c) D2 owed a non-delegable duty of care to the plaintiffs?

[29] Several issues were raised in these appeals, which mirrored somewhat the issues raised at trial. We shall deal with them in that order.

First issue: Did the first defendant inform the second plaintiff of the Caesarean section option?

[30] The crux of the second plaintiff's complaint is that the first defendant did not discuss with the second plaintiff nor offer her the choice of a Caesarean-section ('C-section') delivery having known that she was carrying a large baby. The learned trial judge found in favour of the plaintiffs in this regard and held that the first defendant had failed to discharge her the duty of care owed to the second plaintiff. The finding by the learned trial judge is found at paras 46–78 of the grounds of judgment.

[31] The second plaintiff says that the first defendant did not discuss the possibility of C-section at all. The learned trial judge also concluded that the option of a C-section was never discussed by the first defendant as the attending physician with her patient the second plaintiff. However, we find that the contemporaneous documentary evidence shows otherwise, in that the first defendant did discuss C-section with the second plaintiff. This is also seen in the first defendant's notes recorded a day before the second plaintiff was admitted for induction of labour, where it is noted that the second plaintiff was not in favour of a C-section and preferred a normal delivery by induction of labour. The learned High Court judge had also alluded to this piece of evidence in para 21 of the grounds of judgment, where she noted:

> [21] On 12 May 2014, at 39 weeks four days gestation, Mdm Baljeet consulted D1 and informed her that she had diarrhoea and had vomited overnight. On examination, Mdm Baljeet was found to be dehydrated. Her blood pressure was 127/72 mm Hg and her weight was 92.5kg. Vaginal examination findings were the same as during the previous consultation. The estimated foetal weight was 3.8–4kg. D1's notes state that there was a discussion about induction or waiting until 41

> weeks gestation. *She noted 'induction as Cx still unfavourable* — Needs overnight Prostin, then Syntocinon. If still fails, for LSCS (not keen). Want to try normal. Leave alone — await labour or induce at 41/52. Prefers induction with Prostin. Admit 13 May 14 for Prostin'. According to the ultrasound report, the estimated foetal weight was 3.753 plus/minus 0.548kg and 3.649 plus/minus 0.533kg. (Emphasis added.)

[32] So clearly, the learned trial judge had noted that a discussion between the first defendant and the second plaintiff on the possibility of a C-section had taken place. In fact the plaintiff's expert Dr Milton Lum (SP5) had, based on the first defendant's clinical notes, stated in his Expert Opinion that 'There was documentation that *Dr PD discussed induction and Caesarean section* ...'. The learned High Court judge had also referred to this evidence in her grounds of judgment. However, despite this contemporaneous documentary evidence, the learned trial judge concluded otherwise, and stated in her grounds of judgment that since, '... Dr Lum had given his evidence during the trial before D1, he did not have the opportunity to hear D1's oral testimony that contrary to what was stated in her medical notes or pleaded in her Amended defence, D1 admitted that she did not in fact discuss or offer Mdm Baljeet the option of a caesarean section during the ante-natal consultation or during the process of delivery'. In fact, that part about the first defendant's admission of not discussing or offering C-section option to Mdm Baljeet stated by the learned trial judge in the grounds of judgment is erroneous as there is no such admission by the first defendant.

[33] The testimony of the first defendant in respect of not offering C-section to the second plaintiff was during labour itself and not prior to that during the antenatal consultations. This fact is noted by the learned trial judge by reference to the notes of proceedings as such:

> There was no need for caesarean section at that time because the head was just sitting there ... I did not offer a caesarean section.

We pause here to note the fact that the first defendant candidly admitted in her testimony that on the day of the delivery she 'did not offer caesarean section ... There was no need for a C-section because the head was just sitting there'. However, there is evidence that there was discussion about C-section delivery during the second plaintiff's ante-natal visits.

[34] Thus, when the evidence as a whole is scrutinised, we find that the purported admission by the first defendant that she had not discussed or offered the option of C-section is a clear misdirection on the part of the learned trial judge. The learned trial judge seems to have equated and conflated the first defendant's admission that she did not offer the option of C-section during labour to the discussion that took place between the first defendant and the second plaintiff the day before, which is documented in the first defendant's

clinical notes. The first defendant's testimony cannot possibly relate to the discussion that took place the day before, because the first defendant's clear reference to the 'head was just sitting there', ie baby GTK's head during birthing, could only mean that she was referring to what transpired during labour and delivery, and not prior to that. Hence, that testimony of the first defendant cannot be construed to refer to the discussion between the first defendant and second plaintiff the day before. The first defendant had always maintained that she had long discussions with the second plaintiff, which included discussions on C-section, but unfortunately only noted it once in her clinical notes.

[35] Hence, we find that the learned trial judge's conclusion at para 48 of the grounds of judgment to the effect that the first defendant's testimony supported the second plaintiff's contention that C-section was never discussed is plainly wrong. The said para 48 of the grounds of judgment reads:

> [48] D1's admission corresponds with Mdm Baljeet's testimony that D1 never offered her a caesarean section. Mdm Baljeet when questioned on this issue by D1's counsel during cross-examination, answered as follows:
>
> D1's Counsel: So when she offered you C-section, why did you deny it?
>
> P2: *She did not offer me a C-section, not at any point during the discussion or at any point during the delivery process itself.*

[36] This erroneous finding of the learned trial judge is further compounded by her finding at para 68 of the grounds of judgment that:

> The evidence shows that during the ante-natal visits, the first defendant did not inform Mdm Baljeet of the option of delivery by way of caesarean section. As D1 herself admitted under cross-examination, she did not inform Mdm Baljeet of the option of a caesarean and her claim that she did so in the amended defence was also untrue.

[37] We are of the view that that the above finding of the learned High Court judge is contrary to the evidence that was presented at trial. In fact it does grave injustice to the professional standing of the first defendant. We agree with submissions of learned counsel for the first defendant that contrary to what the learned trial judge held, the evidence showed that the first defendant did inform and discuss with the second plaintiff the option of a C-section during ante-natal consultation. There is uncontroverted evidence in the first defendant's clinical notes to the effect that the second plaintiff wanted to try normal delivery via induction and was not keen on C-section, which would have its own attendant risk. This is borne out by the following entry in the first defendant's clinal notes:

> ... *induction as Cx still unfavourable*. Needs overnight Prostin, then Syntocinon. *If still fails, for LSCS (not keen). Want to try normal*. Leave alone — await labour or

induce at 41/52. Prefers induction with Prostin. Admit 13/05/14 for Prostin. (Emphasis added.)

[38] Further, there is evidence that the second plaintiff's first child, S, a large baby weighing 4.54kg (as informed by the second plaintiff to the first defendant) was delivered via normal vaginal delivery. According to the first defendant, the weight of the first child and the method of that baby's delivery was an important factor that had a bearing on her clinical judgment to go for normal delivery, which was preferred by the second plaintiff. In this regard, the first defendant explained at trial that since the baby (GTK) in the second plaintiff's womb was estimated to weigh between 3.8kg to 4kg she had discussed the delivery option with the second plaintiff and this is recorded in the notes of proceedings in the following terms:

> We were always looking at a vaginal delivery initially because if the fact that a 4.5kg baby can come through her, then the chances of a 3.8kg to 4.0kg would be quite successful. The option for a C-section was also discussed but it came out in the context of if the induction fails, then there would be the option for a C-section. She did not seem happy about it but I had to tell her that this is how it works, sometime inductions don't work. And if induction fails, then the only way to deliver this baby would be by a C-section.

[39] However, in contrast to these evidence, the second plaintiff testified that the first defendant did not '… offer me a C-section, not at any point during the discussion or at any point during the delivery process itself'. This assertion is obviously not borne out by the evidence. And in fact the contrary is evident, in that the possibility of C-section was discussed prior to the second plaintiff's induced labour. This fact is also borne out by the WhatsApp text message exchange between the second plaintiff and the first defendant. In that text message exchange the first defendant had in one of the messages said:

> Hi. Just wanted you to do some reading in advance abt warts and childbirth. Most of us DO NOT do a C-section for warts unless it is blocking the vaginal passage. The risks are very very small to passage baby, I would like you to do some independent reading abt it so that both of you are comfortable abt it before we discuss it further on Monday.

And the reply to that from the second plaintiff was:

> Ok thanks! I have been reading up too was a bit worried earlier. Felt a bit relieved. Its also due to extra moisture bladder control …

So, there is clear evidence that the second plaintiff and first defendant did discuss the C-section option via text messaging and in person at the first defendant's clinic before induction of labour the next day. It was only during labour that there was no further discussion of C-section, as the need for it did not present itself then.

A **[40]** Thus, we find that there is ample evidence supporting the first defendant's contention that she did discuss the option of the C-section with the second plaintiff, and the assertion to the contrary by the second plaintiff that there was no discussion at all on C-section is negated by credible documentary and oral evidence.

B

[41] Hence, we find that the learned trial judge had misdirected herself when she concluded that the second defendant did not discuss nor offer the option of C-section delivery to the second plaintiff. This plainly wrong conclusion needs to be corrected by appellate intervention.

C

Second issue — Did the second plaintiff mislead the first defendant by misinforming the first defendant that her earlier baby delivered by normal vaginal delivery had weighed 4.54kg when in fact it weighed only 3.8kg at birth?

D

[42] Evidence showed that the second plaintiff is a highly intelligent lady, a graduate of Cambridge University with a first Class Honours in Economics. She had extensive experience in finance and was then the Managing Director of Strategy and Portfolio Investment of Samruk Kazyna, the Sovereign Wealth Fund of Kazakhstan.

E

[43] The first defendant testified that the second plaintiff had given a very comprehensive, exhaustive and precise medical and family history when she first consulted the first defendant. The first defendant states that the second plaintiff had stated quite categorically that the birth weight of her first born, a boy named S, was 4.54kg, and that information is recorded in her clinical notes. The first defendant further states that the birth weight of the second plaintiff's first child is an important factor to be taken into consideration in the management of the second plaintiff's pregnancy and delivery. The first defendant stated in her amended defence, as she did in her testimony during trial, that S's birth weight of 4.54kg was one of the primary considerations in she deciding that the second plaintiff would be able to deliver GTK, whose weight was estimated at between 3.8kg to 4kg, by normal vaginal delivery, which was the mode of delivery preferred by the second plaintiff.

F

G

H

[44] However, both the second plaintiff and her husband in their oral testimony denied that assertion and said that they never told the first defendant that S's birth weight was 4.54kg, and were adamant that they had told the first defendant that S's birth weight was 'approximately 4kg'.

I

[45] The learned trial judge rejected the first defendant's assertion that she was informed by GTK's parents that S's birth weight was 4.54kg, which assertion was backed by entries in contemporaneous documents, and instead

chose the oral testimony of the second plaintiff and her husband. In this regard, the learned High Court judge said this at para 132 of her grounds of judgment:

> From the evidence available before this court, I find that D1 had failed to prove on a balance of probabilities that Mdm Baljeet and her husband had informed D1 that S's birth weight was 4.54kg. D1's contention is based on her own record of the first consultation she had with Mdm Baljeet. Both Mdm Baljeet and her husband had denied that they told D1 that S's birth weight was 5.54kg. Also. In their respective witness statements they had stated that S's birth weight was 'approximately 4kg'.

[46] The second plaintiff when testifying in court said that she was shocked to learn sometime in November 2016 that the first defendant was claiming that S's birth weight communicated to her earlier was 4.54kg. However, the evidence showed that apart from the initial entry in the first defendant's notes recorded on the first consultation with the second plaintiff, S's birth weight was also listed as 4.54kg in the insurance form for the second plaintiff which was filled in by the first defendant. The second plaintiff admits receipt of this insurance form on 30 March 2014 but claims ignorance of the contents. If indeed S's birth weight was wrongly stated by the first defendant then the second plaintiff should have corrected it. But she did not.

[47] Then at the grievance meeting called by Pantai Hospital following the second plaintiff's complaint, the first defendant brought up the fact that S's birth weight was 4.54kg on two occasions during the meeting, but the second plaintiff did not correct the first defendant by stating S's correct birth weight, which was a fact known to the second plaintiff and her husband who was present at the meeting. When questioned on this the second plaintiff answered that she did not correct the first defendant apparently because S's birth weight chart was at home and that it was of no relevance at the meeting. How such an important piece of information could be regarded by the second plaintiff to be irrelevant to the issue at hand is baffling, when the first defendant was maintaining her stand that her management of the second plaintiff's pregnancy and the delivery option was very much dependent on the birth weight of her first child.

[48] At trial the first defendant, in reasserting the importance of the correctness of S's actual birth weight, testified as to what had transpired at the grievance meeting in the following terms:

> The meeting was to let both sides talk about it and Mr Taranjeet actually mentioned that he was unhappy with the way things went and things like that. And then, at the end of it, Dr Narayanan then asked me to give my opinion about the whole thing. *So I went in detail and spoke to them about the antenatal, about how I was told that the baby was 4.54kg and how my management depended on that and that this baby is 4kg and it should actually come out because of the fact that if a 4.5kg baby can come out*, I was surprised that a 4kg baby couldn't come out except this baby came out with the

A shoulders in that transverse diameter and because of that, that's what actually caused a lot of the problems. We discussed induction how induction was a good idea because we did not want the baby to be as big as the previous one. *In no way, during that one-hour meeting, was there any objection to me mentioning that I was told that the previous weight was 4.54kg. Mr Taranjeet did not object, neither did the father.* (Emphasis added.)

[49] At the grievance meeting, the second plaintiff's father, Dr Jaswant Singh, was also present. So was her husband Mr Taranjeet Singh. If indeed what the first defendant had said at the meeting was untrue, as now alleged by the plaintiffs, then it would have been incumbent upon the second plaintiff, her husband and her father to have objected to what the first defendant said about S's birth weight and corrected her, and immediately taken her to task for stating something that was untrue. This, however, was not done. The second plaintiff's husband Mr Taranjeet in cross-examination when questioned why he did not refute the first defendant's assertion of S's birth weight being 4.54kg during the grievance meeting, he answered:

I was not there to say it was wrong, I just wanted to hear. And so, when the doctor mentioned, I was not there to argue because I could sense there will be a situation for trial, I could sense it. I am not going to go out there and display things that I have, no, of course not ... So to your question Ma'am, the answer was 'I did not dispute this'.

[50] We find the answer to be wholly unsatisfactory in the circumstances of the meeting which was called to discuss the plaintiffs' grievance and complaint of improper professional care given by the defendants. Surely, the import and purpose of that meeting was to get answers as to what had transpired. If the basis of the first defendant's advice, treatment and care given to the second plaintiff was premised on the erroneous birth weight of S, it ought to have been corrected there and then, and the first defendant confronted on such a lapse of judgment immediately.

[51] Hence, the first defendant's assertion at the grievance meeting that her management of the second plaintiff was premised on the medical and family history that the second plaintiff had given, including the birth weight of S, was never refuted nor challenged by the plaintiffs.

[52] Additionally, on 17 December 2014, in response to the plaintiffs' solicitor's request before the suit was filed, the first defendant furnished a medical report regarding the second plaintiff's admission and treatment at Pantai Hospital and her delivery of GTK. The second paragraph of that medical report states: 'Her first pregnancy had been in 2003. She had delivered a 4.54kg baby at Damansara ...'. Despite this assertion, the second plaintiff testified that she was shocked to find out sometime in November 2016, ie some

two years later, that the birth weight of S was noted by the first defendant as 4.54kg, when in fact that medical report was made available to the plaintiff's solicitors well before the writ was filed.

[53] The evidence showed that the first defendant had been consistently stating S's birth weight in several contemporaneous documents as 4.54kg and these were never refuted by the second plaintiff. In fact the plaintiffs' own expert witness Dr Milton Lum had stated S's birth weight in his report as 4.54kg. At the very least one would have expected the plaintiffs to have corrected their own expert's erroneous statement of fact in his report, and yet this was also not done.

[54] Further, when the plaintiffs filed their writ and statement of claim on 7 December 2015, the plaintiffs made no mention of this erroneous recording of S's birth weight as 4.54kg in the first defendant's clinical notes. Neither was there a denial of the first defendant's statement in her medical report of 17 December 2014 that the second plaintiff's '... first pregnancy had been in 2003. She had delivered a 4.54kg baby at Damansara ...'. S's birth weight is undoubtedly a crucial and pivotal point, especially when GTK was a larger than normal baby, yet the plaintiffs' statement of claim remained silent on it.

[55] In addition to that, the first defendant's expert Dr Theva Raj after having taken history directly from the second plaintiff had also recorded S's birth weight as 4.54kg in his report dated 7 September 2016. Neither was this ever corrected by the plaintiffs.

[56] It was only in November 2016, on the first day of trial scheduled before John O'Hara J that the plaintiffs for the first time ever disclose S's birth chart. By then all bundles of documents had been filed including the first defendant's medical notes, the insurance document, medical reports and expert reports all containing S's birth weight as 4.54kg. This 11th hour disclosure necessitated an adjournment of the trial and the need for the first defendant to amend her defence.

[57] It is common ground that the second plaintiff always had in her possession S's birth weight chart documenting his birth weight as 3.8kg. This was however never shown to the first defendant, nor produced in the bundle of documents, prior to that aborted first day of trial. In light of this 11th hour revelation, the first defendant amended her defence, and subsequently testified at length that had she been given the correct birth weight of S by the second plaintiff when she had first taken her medical history, then the entire management of the second plaintiff would have been different. The first defendant said that she would have insisted on a C-section, and there was no

way she would have agreed to a vaginal delivery of a baby the size of GTK had she known of the weight of the second plaintiff's first baby was 3.8kg. The first defendant had further testified:

> This vital information is very important because in my mind then, she at 42 weeks had delivered a, lets out it at 4.5kg baby and thus I then would imagine that the chances of the next baby being almost the same size or even bigger is very high. So during the antenatal visits, I have to then watch the size of the baby during my ultrasound and during my measurements of her tummy to advise her accordingly of what would be the potential size of this baby at delivery because that would be then very important for the type of delivery that she is going to have. Now, during these conversations there was a lot said about how she did not wasn't this baby, the second pregnancy, to be as big as the first one, this was emphasised over and over again.

[58] In this regard, we agree with submissions of counsel for the first defendant that the uncontested documentary evidence, and the conduct of the second plaintiff leading up to the trial, clearly shows that the second plaintiff had misinformed the first defendant of S's birth weight right from the very beginning thus setting the first defendant on a path of management of the second plaintiff's pregnancy and delivery based on that misinformation. Hence, we find that the learned trial judge had erred and misdirected herself when she disregarded all these evidence, particularly the contemporaneous documentary evidence, and made a finding that 'D1 had failed to prove on a balance of probabilities that Mdm Baljeet and her husband had informed D1 that S's birth weight was 4.54kg' based solely on the self-serving oral testimony of the second plaintiff and her husband. The learned High Court judge had failed to critically analyse and evaluate the plaintiffs' contemporaneous conduct in this regard. See *Tindok Besar Estate Sdn Bhd v Tinjar Co* [1979] 2 MLJ 229; [1979] 1 LNS 119 where the Federal Court held:

> Judicial reception of evidence requires that the oral evidence be critically tested against the whole of the other evidence and the circumstances of the case.

Subsequently, the then Supreme Court in *Eastern & Oriental Hotel (1951) Sdn Bhd v Ellarious George Fernandez & Anor* [1989] 1 MLJ 35 speaking through Wan Hamzah SCJ after quoting with approval the following observation made in *Armagas Ltd v Mundogas SA; The Ocean Frost* [1985] 3 All ER 795; [1985] 1 Lloyd Rep 1, had stated:

> It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents to the witnesses' motives, and to the overall probabilities can be of very great assistance to a judge in ascertaining the truth, said:
>
> > In commercial cases there is usually a substantial body of contemporary documentary evidence.

> This is not strictly speaking a commercial case, but the relevancy of contemporaneous documents nevertheless holds true.

This was reiterated by Siti Norma Yaakob JCA (later CJM) in *Guan Teik Sdn Bhd v Haji Mohd Noor bin Haji Yakob & Ors* [2000] 4 MLJ 433; [2000] 4 CLJ 324, speaking for the Court of Appeal:

> In cases where conflicting evidence are presented before a court, it is the duty of the court not only to weigh such evidence on a balance of probabilities but it is also incumbent upon the court to look at all the surrounding factors and weigh and evaluate contemporaneous documents that may tend to establish the truth or otherwise of a given fact.

The learned trial judge ought to have tested the second plaintiffs' oral evidence, and that of her husband, against the entirety of the evidence and circumstances of the case, to draw the appropriate inference and conclusion in order to ascertain where the overall probabilities lie. However, the learned trial judge failed to do so, and merely accepted the self-serving oral testimony of the second plaintiff and her husband in contradiction to the evidence contained in the contemporaneous documentary evidence. The failure to do so indicates that there is insufficient judicial scrutiny and appreciation of the evidence, which warrants appellate intervention.

[59] There is a duty on the learned trial judge to consider all these pieces of credible documentary evidence instead of accepting inherently improbable and partial oral testimony, as noted by this court in *Theow Say Kow @ Teoh Kiang Seng, Henry v Graceful Frontier Sdn Bhd & Ors and other appeals* [2020] MLJU 57; [2020] 1 LNS 52:

> *All these pieces of strong and credible evidence ought to have been considered by the learned Judge instead of accepting inherently improbable evidence, which frequently came across as contrived and partial.* Having carefully perused the records of appeal and having considered the submissions and the grounds of judgment, we find ourselves in full agreement with learned counsel for the appellant that the evaluation and appreciation of evidence was not fair or balanced. *Relevant contemporaneous documents such as those that we have discussed above were not considered or properly examined with the learned Judge frequently misdirecting himself. In these circumstances, the decision reached was plainly wrong and was one which no reasonable judge could have reached.* (Emphasis added.)

[60] We have noted that the first defendant is a consultant obstetrician and gynaecologist who obtained her basic MBBS qualification from the University of Delhi in 1989. She did her district posting as Medical Officer in Malaysia in Klang and Tanjung Karang, Selangor and went on to graduate from University of Malaya with Masters of Medicine (Obstetrics and Gynaecology) in 1995. She then served for five years as an Associate Professor in the Department of

Obstetrics & Gynaecology at University Malaya. She served 11–12 years in total in government service before going into private practice at Pantai Hospital in 2001.

[61] We have further noted that the first defendant's clinical notes on the history of the second plaintiff were comprehensive and exhaustive. The only point of contention is the birth weight of S, which the second plaintiff and her husband Mr Taranjeet now contend was given merely as 'approximately 4kg' and not 4.54kg as noted by the first defendant. It is highly improbable that a physician of the first defendant's calibre and experience would have just plucked a figure of 4.54kg out of thin air, and that too right down to two decimal points.

[62] In this regard, we agree with submissions of learned counsel for the first defendant that S's birth weight was a crucial piece of information, and if the plaintiffs' version that they had merely given S's approximate and not exact birth weight is correct, then it must necessarily mean that the first defendant, an established and reputable medical specialist with almost 30 years' experience still somehow managed to misunderstand the second plaintiff and her husband, and had mixed up the precise figure of 4.54kg with 'approximately 4kg'.

[63] And additionally, it would mean that this mistaken figure was then erroneously entered into the medical records by the first defendant, not only in the clinical notes, but also her medical report, insurance form, and orally repeated at the grievance meeting. And strangely this mistaken figure is repeated by the plaintiff's own expert, Dr Milton Lum, and by the first defendant's expert Dr Theva Raj, after having taken history directly from the second plaintiff, without any attempt by the second plaintiff to correct it.

[64] The conduct of the plaintiffs in not correcting all these entries, if indeed S's birth weight was wrongly stated, speaks volumes about their contention that they were shocked to find out about it only sometime in November 2016. The second plaintiff had known of it much earlier and chose not to challenge that. Hence, the irresistible conclusion to be drawn from all these evidence is that the second plaintiff had misinformed the first defendant about S's birth weight, and then contrived to hide that fact when it became evident to her that the actual birth weight of S was a crucial piece of information for the first defendant in her management of the second plaintiff's pregnancy and delivery.

[65] Hence, had the learned trial judge applied the law correctly and asked herself the right question, that is, whether the defence version is consistent with the probabilities of the case, she would have as a reasonable tribunal rejected the plaintiffs' version as improbable and accepted the first defendant's version. This

failure on the part of learned trial judge has cause a miscarriage of justice that warrants appellate intervention.

Third issue — Was the first defendant entitled to rely on the history provided by the second plaintiff to plan the management of the pregnancy and delivery of the baby?

[66] The first defendant did take a very comprehensive and detailed medical and family history of the second plaintiff, which would be necessary for the first defendant's management and treatment of the second plaintiff's pregnancy. However, the learned High Court judge in her grounds of judgment held that:

> D1 as her attending obstetrician should have informed her that providing an accurate birth weight of her older son is important for D1 to advise her of the appropriate delivery options.

We respectfully disagree with that postulation. A physician is required by law to take the patient's history. However, we do not find any principle in law that imposed a duty on the physician to explain to the patient that giving an accurate and truthful history is important. It is implicit in the history taking exercise itself that the history that is given by the patient must be accurate, otherwise it may mislead and misdirect the physician in his treatment and management of the patient. If the first defendant in the course of the antenatal consultations had neglected to ask the second plaintiff about her medical history and S's birth weight and the mode of delivery, then it could be said that the first defendant had breached her duty of care. However, here the first defendant did ask specifically for S's birth weight and mode of delivery. The issue only relates to what was the answer given by the second plaintiff, which was recorded by the first defendant. The first defendant recorded the answer that was given, which recording is now contested by the plaintiffs as inaccurate.

[67] The law cannot impose a burden on an attending physician to inform or warn the patient to give accurate answers to the questions posed during history taking, or for that matter to ensure that the patient's answers are accurate and truthful. The patient ought to know of his own duty to speak truthfully and give accurate information to the attending physician, which information could form the basis of diagnosis and the treatment plan. To place an added burden on the first defendant, or for that matter on any attending physician, to not only take the patient's history but also to convince the second plaintiff that the history must be accurate is not a duty recognised in law. The duty is in fact on the patient to give accurate information and history when the same is asked by the physician.

[68] We are of the considered view that it is not imperative or wise to impose a general duty on physicians to make enquiries from their patient's previous

physicians or hospitals as to the patient's medical history. Whilst there is a duty on the physician to take proper history of the patient, we cannot expand that duty to include a requirement for the physician to reach out to the patient's previous physicians or hospitals. As explained earlier, if the facts of a particular case requires the previous medical history that the patient himself was unable to provide, or provide with some degree of accuracy or completeness, then the physician may have to reach out to the previous physicians or hospitals with the patient's consent. That is a judgment call best left to the physician.

[69] In the circumstances, we see no useful purpose in imposing a general duty on a doctor to make any enquires from the patient's previous doctors or hospitals. Such a duty if imposed would be counterproductive as medical professionals would be obligated to spend considerable amount of time and energy tracking down physicians and hospitals from the patient's past, failing which they would leave themselves open to allegations of malpractice. Such a burden, if imposed, would also mean that doctors would be unable to safely rely on the oral history given by a patient, even if they are properly documented and no matter how clear and exhaustive. The patients too would be inundated with increased costs arising from defensive medical practice. That cannot be in the best interest of the patient nor the medical profession. Let us be clear, the law does not and would not impose such an onerous general duty on physicians that would have a crippling effect on the medical profession as a whole.

[70] In this case, the first defendant testified that in respect of taking patient's history, she had done that when she first met the second plaintiff and her husband during the initial antenatal consultation. The first defendant testified that she had taken a detailed history from both the second plaintiff and her husband Mr Taranjeet. She said that it was:

> ... told to me by Mdm Baljeet and Mr Taranjeet when I was asking them details of their previous delivery and they were very specific and I was told the weight up to decimal points. History taking in the first visit is very important and if you go back to the same page, [of D1's notes] there were very detailed remarks about her past medical history in terms of slipped disc, about kidney stones, about how her mother's borderline blood pressure, all these things are taken in detail during that first visit, along with details of the first delivery, where it was conducted, how many weeks pregnant she was, was it a spontaneous labour or in this case, she told me that it was an induced labour because she had gone beyond her dates.

[71] Hence, there is ample evidence showing that the first defendant had discharged her duty to take proper patient's history when she saw the second plaintiff and her husband at the first consultation. Counsel for the plaintiffs urged this court to rule that there was a duty imposed upon the first defendant after taking history from the second plaintiff to make further enquiries from the second plaintiff's previous physician to ascertain the accuracy and veracity

of the information given by the second plaintiff. We do not find any cogent reason for this court to impose such a duty on an attending doctor. If the history given by the patient is sketchy or wanting in any respect, then it must be left to the doctor to make a clinical judgment as to whether such further enquiry is required. We agree with counsel for the first defendant that unless there is manifest reason to suspect that the history given is materially incorrect or incomplete, doctors should be allowed to rely on their clinical judgment to decide how far one needs to go to ascertain whether the quantity and quality of the patient's history proffered is adequate and sufficient for the doctor to give proper medical advice and to devise a plan of treatment and care that is safe and effective for that particular patient. Here, the first defendant states that the second plaintiff described her first child's birth weight right down to the decimals, and the same is recorded by the first defendant in her notes. There is nothing to indicate that the second plaintiff, nor her husband, were uncertain of S's birth weight.

[72] If indeed it was established that the second plaintiff had offered imprecise history with vague or ambiguous details, then perhaps it could be argued that the second defendant should have made further enquiries, including perhaps obtaining the second plaintiff's consent to reach out to her previous obstetrician/gynaecologist who had attended to the delivery of S. In rejecting this argument by counsel for the plaintiffs, we take note of the fact that the second plaintiff had given quite a detailed medical history of herself, including her mother, and the only point of contention is the birth weight of S as recorded by the first defendant in her notes. In the circumstances, and on the face of it, it cannot be gainsaid that the quality of history given by the second plaintiff was wanting or that the first defendant had been put on notice to make further enquiries. Given the fact that the second plaintiff was a highly educated women, and that both husband and wife were present when the patient's and family medical history was taken, and the detailed history that was given, we do not find any reason at all for the first defendant to have made further enquiries with the second plaintiff's previous physician, particularly in respect of S's birth weight, when his birth weight right down to two decimal points were given and recorded.

[73] Hence, the simple answer to this third issue is that the first defendant was entirely justified in relying on the information given by the second plaintiff as part of her medical history, including the birth weight of S and the manner of his delivery, in formulating her treatment plan and advising on the delivery option. We do not find any breach of duty in this regard by the first defendant.

Fourth issue — Did the first defendant fail in her duty to properly advice, inform and warn the second plaintiff of the risks of a normal delivery?

[74] The law imposes a general duty on a physician to properly advice and inform the patient of the treatment options, and the attendant risk. Here, the second plaintiff's preference was for a normal delivery. However, if the medical condition of the patient was such that a normal delivery would have heightened risk, then in would be incumbent upon the first defendant to inform, advice and warn the second plaintiff of those risk and discuss alternative delivery options. The second plaintiff complains that the first defendant did not do so considering the baby was large and there could be inherent complications in a normal delivery of such a large baby. In respect of this issue, the learned trial judge held as follows:

> Therefore, based on the applicable law, whether or not Mdm Baljeet gave D1 the correct birth weight for her elder son, it does not remove D1's duty as a doctor to advise her patient, Mdm Baljeet, of the available delivery options and the pros and cons of each option so as to enable Mdm Baljeet to make informed choice. The evidence shows that D1 did not discuss with Mdm Baljeet the option of delivery by Caesarean section and the risk of shoulder dystocia; nor did she discuss the pros and cons of vaginal delivery and delivery by way of caesarian section. Although, D1 noted that the baby in utero was a 'big baby' and that the baby's estimated feotal l weight was 3.8–4kg, she failed to advise Mdm Baljeet that there is a high risk that the baby will be macrosomic. She also failed to advise Mdm Baljeet that there is a risk of shoulder dystocia during the vaginal delivery of a macrosomic baby. As the UH study concluded, macrosomia is a predictor of shoulder dystocia in babies weighing 3.5kg or more.

The learned judge added:

> Also, as Dr Milton Lum testified, babies generally are larger as birth order increases. These are facts known as a consultant obstetrician and gynaecologist but not to Mdm Baljeet, who as the patient is owed a duty of care by D1 to advise her and provide her with all this information.

[75] In short the learned trial judge found that the first defendant had failed to discharge her duty to properly advice, inform and warn the second plaintiff on the delivery options.

[76] We agree with learned counsel for the first defendant that this issue cannot be dealt with in isolation, as it is intrinsically linked to the question of whether the second plaintiff had given proper and accurate history at the outset, particularly whether the second plaintiff had given the accurate birth weight of her first born child. This information is crucial to the first defendant in her management plan for the second plaintiff as the correct birth weight of the first child would have been one of the determining factors in the type of

delivery option that the first defendant would have recommended or taken. This was in fact confirmed by the first defendant in her testimony at trial, where she said:

> The issue of 3.8kg only came in 2 years later, from 14 May 2014 that we were informed that the baby was 4.54kg. It changes the whole scenario because we doctors depend on information that's given to us during the visits to the hospital.
>
> Now, if I am told that a baby was 2 weeks post-date, that means 42 weeks of pregnancy and at that point, the baby was 3.8kg and I'm trying to deliver a baby at 40 weeks, I have to minus a few grams. Now, normally a normal baby at 40 weeks, that baby should be 3.5kg and less.
>
> Now, she had a vacuum delivery for a 3.8kg at 42 weeks. I cannot afford to have a baby that's weighing 3.8kg to 4kg at 40 weeks of pregnancy. I would have then changed the whole scenario and said, let's get a C-section done because it is very important that, if this baby is going to get bigger, then the chances are that you're going to have a higher risk of instrumental deliveries, a higher risk of vaginal tears or even, in the worst case scenario, running with you for an emergency C-section and that's not what I would have wanted for her. So information that is given to us by the patient is critical because it plays a big role in how we manage them in subsequent pregnancies.

The first defendant added:

> So we had a healthy young women, we had a reasonably sized baby, we were inducing at 40 weeks, the question of C-section came in only if there was an emergency. So that was the discussion that went on most of the time.

[77] Obviously, the first defendant's management of the second plaintiff was premised on the believe that if the second plaintiff had been able to give safe passage to a 4.54kg baby, then so long as the first defendant took the necessary precaution to ensure that the present baby's weight did not exceed 4kg then there is no appreciable or increased risk of shoulder dystocia. This is not only logical, but is medically supported. The first defendant did precisely that based on the information that was given by the second plaintiff. In the circumstance, to heap blame unto the first defendant for not discussing a possible C-section because of the size of the baby, is to our mind, wholly untenable self-serving post-delivery blame game, which, with respect, the learned trial judge ought to have rejected.

[78] Further, it was argued that since the baby's estimated weight was more than 3.5kg, it was by reference to the University Hospital standards a macrosomic baby. The risk of shoulder dystocia is higher with macrosomic babies and hence a C-section delivery would have been more appropriate. However, when this was asked of the plaintiffs' expert witness Dr Milton Lum, he said that whether the baby is macrosomic is relative and it depends on what

definition is used. He explained:

> Well it depends whether you use a western definition or Malaysian definition. In the paper that I referred to from University Malaya, which is found on page 30, they use a definition of 3.5kg, right at the top. 'Objective to determine if shoulder dystocia can be predicted in babies born weighing 3.5kg or more', so they use that definition. But if you are looking at papers from Europe, North America or Australia, they would be using a definition of 4kg or 4.5kg. So it depends on which setting that you are practicing in.

[79] It is obvious from the expert evidence that the definition and measure of a macrosomic baby not only refers to the foetal weight but also depends on the height and built of the mother. In Europe, Australia and North America, where the women are generally taller and bigger built, they are expected to deliver larger babies of between 4 to 4.5kg without the risk of shoulder dystocia, and as such, babies below 4 to 4.5kg are not considered macrosomic. However, in Asia, particularly Malaysia, women are not as tall and are of smaller built and as such babies above 3.5kg are considered macrosomic. Now, even though we are in a Malaysian setting, the second plaintiff, standing at 172cm (174cm in some other records) is not of the normal Asian built. In fact she would be more akin to European/North American women in height and built. Hence, to apply the University Hospital standards universally to all women who give birth in Malaysia would not be accurate in the circumstance. Hence, in applying the University Hospital standards on macrosomic babies, regard must be had to and consideration given to the actual height and built of the mother and the antecedent history of the mother's previous deliveries. Thus, when viewed against the backdrop of the first defendant's understanding that the second plaintiff was able to deliver a 4.54kg baby earlier and the fact that the second plaintiff is a tall women at 172cm, and in view of the variance in the literature of what is considered a macrosomic baby, we are of the opinion that the first defendant cannot be faulted for making a clinical judgment that the second plaintiff's baby, estimated at between 3.8 to 4kg in weight, would not be at risk of shoulder dystocia nor would it present unusual risk to the second plaintiff such that the first defendant ought to have discussed and offered the C-section alternative to the second plaintiff.

Fifth issue — Did the first defendant undertake the correct management of shoulder dystocia during labour and delivery

[80] Shoulder dystocia occurs when, after vaginal delivery of the head, the baby's anterior shoulder gets caught above the mother's pubic bone. This is regarded as a delivery room emergency. Medical literature shows that although many factors have been associated with shoulder dystocia, most cases occur with no warning. However, calm and effective management of this emergency is possible with recognition of the impaction and institution of specified

manoeuvre, such as the McRoberts manoeuvre, suprapubic pressure, internal rotation, or removal of the posterior arm, to relieve the impacted shoulder and allow rotation for spontaneous delivery of the infant.

[81] The plaintiffs alleged that after the vaginal delivery the baby's head using forceps, and when further passage of the baby through the birth canal was obstructed by shoulder dystocia, the first defendant failed to perform the McRoberts manoeuvre on the second plaintiff as an emergency intervention to help the baby's shoulders move through so that the baby can be delivered safely and without injury. The plaintiffs further alleged that even if the McRoberts manoeuvre was performed, it was not performed properly, thus causing injury to baby GTK and the second plaintiff. Hence, the plaintiffs contended that this failure was a breach of duty of care, which had caused pain and suffering to them.

[82] In this regard, the learned High Court judge found as follows:

> In my view, D1's failure to undertake the McRoberts maneuver correctly and apply the suprapubic pressure before applying traction to deliver the baby, constitutes a breach of her duty of care. As nurse Ng testified, D1 had 'pulled out the baby' before the McRoberts maneuver could be undertaken. Nurse Ng's testimony shows that the McRoberts maneuver was not undertaken although D1 had written in her clinical progress notes that 'McRoberts done by nurses immediately'. The evidence shows that D1 did not apply suprapubic pressure or enlarge the vaginal opening through an episiotomy, before pulling the baby out.

In short, the finding of the learned trial judge was that the first defendant had failed to undertake the McRoberts manoeuvre correctly, particularly by the failure to apply suprapubic pressure before applying traction to deliver the baby.

[83] We noted that the McRoberts manoeuvre, named after William A McRoberts, Jr, is an obstetrical manoeuvre used in case of shoulder dystocia during childbirth. The manoeuvre typically involves hyper-flexing the mother's legs tightly towards her abdomen, usually assisted by trained nurses, which effectively increases mobility at the sacroiliac joint, thus allowing rotation of the pelvis and facilitating the release of the foetal shoulder that is stuck. In the event that the manoeuvre is not successful, one of the attending medical personnel applies pressure on the lower abdomen (suprapubic pressure) ie placing pressure on a certain area of the patient's pelvis to encourage the baby's shoulder to rotate. A combination of these two techniques, ie McRoberts manoeuvre and application of suprapubic pressure has a very high rate of success.

[84] Despite at one point saying that the McRoberts manoeuvre was

incorrectly carried out, the learned trial seems to conclude based on the testimony of nurse Mdm Ng Soo Ling (DW4) that the first defendant did not carry out the McRoberts manoeuvre at all, even though the first defendant had recorded in her notes that McRoberts manoeuvre was done. This finding of the learned judge does not seem to take into account the testimony of the first defendant where she had stated that she had indeed carried out the manoeuvre. The following evidence is important in this regard:

> Q: Counsel for the plaintiff asked you that there should be 3 persons doing the McRoberts and you disagreed. Please explain why.
>
> A: The McRoberts, if you have 2 able-bodied staff nurses next to you, you can already start off the McRoberts without delaying any further. The call bell is next to Staff Nurse Vanitha, the nursing counter is just 5 steps away. I did not waste any time. I asked them to start the McRoberts. Subsequently I put my hand into the vagina and started my rotation technique. And in less than a minute the baby actually came out. The additional nurses or any other personnel would not have any further help at that point, the baby is already out.
>
> Q: Now Counsel for the plaintiff also asked you about suprapubic pressure being part of McRoberts and you disagreed?
>
> A: Again if I can go forward, McRoberts and suprapubic pressure are 2 different maneuvers, they are not part and parcel of one. McRoberts is when we flex and abduct the legs towards the mother's body to increase diameter. That itself aids with delivery of the baby. Suprapubic pressure is then an additional maneuver to help pull the baby out.
>
> Q: Was there any suprapubic pressure in this case?
>
> A: There was no suprapubic pressure and I would be wrong to put suprapubic pressure because the baby's back is like this, if I had put suprapubic pressure, I would be putting pressure at the base of the baby's neck and I could have caused more injuries.

[85] The evidence as a whole shows that the McRoberts manoeuvre was indeed carried out by the first defendant. There is in fact evidence from the second plaintiff that two nurses were holding her legs inwards, which is part of the McRoberts manoeuvre. Further Nurse Ng said '… we had extended the leg, the diameter is wider and helped her', which is again indicative of the manoeuvre being done. Thus, when the evidence is considered in its totality it is more probable than not that the McRoberts manoeuvre was done by the first defendant when the baby had shoulder dystocia.

[86] In some parts of her testimony Nurse Ng seems to be confused and she confessed to that much when she said '… I may have forgotten you see, I don't know, sometimes you get distracted …'. And she further added '… you see during that emergency, exactly the whole scene you cannot sort of pick on every bit of it you see'. There is no denying that the medical team was dealing with an

emergency, and Nurse Ng's recollection of the events and the details during the emergency were at times wanting. Hence, for the learned trial judge to have placed too much reliance on the evidence of Nurse Ng without considering the overall evidence before the court when concluding that the manoeuvre was not done, is with respect a misdirection.

[87] We find that the evidence as whole showed that the McRoberts manoeuvre was in fact carried out. The question then is whether the McRoberts manoeuvre was carried out properly? In this regard, the learned High Court judge held that the manoeuvre was not done properly and observed as such in the grounds of judgment:

> I find that from Nurse Ng's testimony, it is clear that the D1 had 'pulled the baby out' before the McRoberts maneuver was completed and suprapubic pressure was applied. Mdm Baljeet testified that excessive force was used when D1 had used the forceps to deliver GTK. When D1's counsel suggested to Mdm Baljeet during cross-examination that D1 delivered the Baby with one pull, Mdm Baljeet replied:
>
> > That is wrong, it was not one pull. She yanked the forceps into my vagina with such force my butt moved off the table and then she proceeded to yank me with her entire body force. And then once she had done that about 2 or 3 minutes, and the baby's head came out. So exactly what do you mean that by one pull because that was not what occurred in the delivery room, my baby was badly. This is flawed and fabricated.

[88] We find that the learned High Court judge's finding that the first defendant had pulled out the baby before the McRoberts manoeuvre was completed is erroneous for reasons which we have alluded to earlier, and which we shall discuss below. Firstly, the term 'delivery by forceps' does not refer to actual delivery of the entire baby, it only refers to the delivery of the baby's head through the birth canal. Hence, we agree with counsel for the first defendant that the learned trial judge's finding that excessive force was used by the first defendant when she used the forceps to deliver the baby is erroneous on two counts. First, the baby was not delivered using forceps, the delivery of the baby came a little later after the first defendant had instructed the midwives/nurses to initiate the McRoberts manoeuvre and the first defendant manually rotated the stuck baby by inserting her hands into the second plaintiff's vagina. Secondly, there was no evidence of any bruises on the baby, which negates the second plaintiff's assertion that the forceps were used in a violent manner. This was further corroborated by Nurse Ng's testimony that no excessive force was used. Additionally, Dr Chai Pei Fan (PW1), the paediatrician who was on standby for the second plaintiff's delivery, had made available his notes to the court and in it apart from shoulder dystocia, there is no indication of any bruising or injury that would be consistent with the second plaintiff's claim that she was yanked about so violently that the second plaintiff's 'butt moved

off the table'. The second plaintiff's version of what happened at the delivery room is not borne out by the testimony of the midwife/nurse or the paediatrician's medical notes, nor by the first defendant's notes and testimony.

[89] The medical evidence shows that when the second plaintiff's legs were flexed towards her abdomen, the first defendant was able put her hands into the second plaintiff's vagina and rotate the baby using her rotation technique, and in less than a minute the baby came out. This indicates that the McRoberts manoeuvre was a success, and there was no need to apply suprapubic pressure, which is only necessary when McRoberts manoeuvre fails. This was also confirmed by the first defendant's expert witness, Dr Mureli, in cross-examination were he said that in cases of shoulder dystocia, the McRoberts manoeuvre should be employed to try to deliver the baby. If the baby is still not delivered, suprapubic pressure should then be applied when the mother is in the McRoberts position to try to free the shoulder. In fact the first defendant explained that considering the position in which the baby was stuck, if she had applied suprapubic pressure she could have caused injury to the baby. This was explained by the first defendant in the following terms during re-examination:

> Q: Now counsel for the plaintiff also asked you about suprapubic pressure being part of McRoberts and you disagreed?
>
> A: Again if I can forward, *McRoberts and suprapubic pressure are 2 different maneuvers, they are not part and parcel of one. McRoberts is when we flex and abduct the legs to wards them other's body to increase diameter. That itself aids with delivery of the baby. Suprapubic pressure is then an additional maneuver to help pull the baby out.*
>
> Q: Was there any suprapubic pressure in this case?
>
> A: *There was no suprapubic pressure and I would be wrong to put suprapubic pressure be ca use the baby's back is like this, if I had put suprapubic pressure, I would be putting pressure at the base of the baby's neck and I could have caused more injuries*. (Emphasis added.)

[90] Suprapubic pressure was clearly not indicated and the first defendant had clearly explained the reason why she did not apply suprapubic pressure. The reason proffered by the first defendant is well supported by medical literature and opinion, and the factual circumstance of the case did not warrant the application of suprapubic pressure. In fact, the application of suprapubic pressure may have brought about further complication and injury to the baby.

[91] Nevertheless, the learned trial judge found the first defendant to have breached her duty of care for failure to apply suprapubic pressure. In this respect, the learned trial judge held as follows:

> [115] In my view, D1's failure to undertake the McRoberts the manoeuvre correctly and apply the suprapubic pressure before applying traction to deliver the baby,

constitutes a breach of her duty of care. As nurse Ng testified, D1 had 'pulled out the baby' before the McRoberts manoeuvre could be undertaken. Nurse Ng's testimony shows that the McRoberts manoeuvre was not undertaken although D1 had written in her clinical progress notes that 'McRoberts done by nurses immediately'. The evidence shows that D1 did not apply suprapubic pressure or enlarge the vaginal opening through an episiotomy, before pulling the baby out.

[116] I find that based on the available evidence, the plaintiffs have proven on a balance of probabilities that the brachial plexus injury to baby GTK's shoulder was caused by D1's mismanagement of the shoulder dystocia, by her failure to follow established clinical protocols in dealing with cases of shoulder dystocia and by the manoeuvre she had used in pulling the baby out. I accept Dr Milton Lum's evidence that in his expert opinion that it can be inferred from the medical records that excessive traction was applied by D1 during the delivery. I find his opinion to be reasonable, responsible, respectable and stands up to logical analysis.

[117] For these reasons, I conclude that D1 had breached her duty of care in managing the shoulder dystocia during the delivery and that she had failed to apply the requisite standard of care in delivering baby GTK and that her breach of her duty of care had caused GTK to suffer brachial plexus injury to her left shoulder.

[118] This court concludes that but for D1's failure to advise and provide Mdm Baljeet with the delivery options and the information necessary for her to make an informed choice and D1's failure to comply with established medical protocols and the applicable standard of care in shoulder dystocia cases during delivery, GTK would not have suffered brachial plexus injury to her left shoulder and Mdm Baljeet would not have suffered the injury to her perineum.

In coming to that conclusion, the learned trial judge had also relied on the evidence of Dr Milton Lum, and this noted in the grounds of judgment:

[103] Dr Lum concluded that GTK's brachial plexus injury was likely to have been caused by excess traction. He stated as follows, at para 6.4.c at p 20 of his expert's report, as regards the management of the shoulder dystocia during Mdm Baljeet's labour:

c. The management of the SD (shoulder dystocia), which resulted in GK's BPI (GTK's brachial plexus injury), was substandard because:

(i) There was no documentation that the signs of the SD (Paragraph 5.5h) were promptly recognised.

(ii) Dr PD (Dr Premitha Damodaran) failed in her attempt at McRoberts manoeuvre (Paragraph 4.25). Although it is unclear whether suprapubic pressure was applied (Paragraph 5.5p), it would have been difficult for one of the two nurses present (Paragraph 4.26) to assist in the McRoberts manoeuvre and apply suprapubic pressure concomitantly. As there are fewer attendants than necessary, it is likely the McRoberts manoeuvre could not be executed properly.

(iii) It is likely that GK's BPI (GTK's brachial plexus injury), was caused

by excess traction (Paragraph 5.6c-5.6e).

However, contrary to what Dr Milton Lum said, when the evidence as whole is considered, it is quite evident that the shoulder dystocia was promptly recognised by the first defendant, that much is confirmed by the earned trial judge in her grounds of judgment. Immediately the McRoberts manoeuvre was carried out, and contrary to the opinion of Dr Milton Lum, the manoeuvre was successful in combination with the hand rotation employed by the first defendant. There was no need for the application of suprapubic pressure. Hence, we do not find any evidential support for Dr Milton Lum's opinion that baby GTK's bracial plexus was caused by excess traction.

[92] We find that for reasons discussed earlier the finding by the learned trial judge is, with respect, untenable. We find that to fault the first defendant for not applying suprapubic pressure, when the same is not indicated, is entirely misplaced. Therefore, the learned trial judge's finding that the non-application of suprapubic pressure is a breach of the first defendant's duty of care is, with respect, untenable for it is not supported by evidence and the law.

[93] It must be noted that once the baby's head was delivered with the aid of forceps, the first defendant was racing against time as the umbilical cord was wrapped tightly around the baby's neck. Dr Milton Lum, the plaintiff's expert confirmed that fact. The fact of the matter is that the first defendant had an emergency at hand. The umbilical cord was wrapped tightly around the baby's neck and after the cord had been clamped the blood supply from the placenta would be interrupted. The first defendant was racing against time to get the baby out. It is all very well for experts with the luxury of time to deliberate at length to find and attribute fault. The first defendant had made a clinical judgment call that the second plaintiff having delivered a 4.54kg baby previously via vaginal delivery should not have any difficulty delivering a 4kg baby now. This should have been a straight forward delivery. Instead, the baby was stuck. The first defendant had a case of shoulder dystocia at hand and an emergency situation where the baby's life was in jeopardy. There was a flurry of activities, McRoberts manoeuvre was done. The baby was still stuck in a position that the first defendant had never encountered, where the baby did not face the thigh of the mother after her head came out but was instead looking down. The risk of the baby asphyxiating was very real and it needed quick action on the part of the first defendant. The first defendant, in combination with the McRoberts manoeuvre put her hand into the second plaintiff's vagina and rotated the baby and managed to release and pull the baby out. In the circumstance we fail to see how the first defendant could be said to have failed to discharge the standard of care that was required of her as an obstetrician. What the first defendant did to attend to the emergency is in our view well within accepted medical practice and the same was confirmed by the first

defendant's expert witness, Dr Mureli, an obstetrician and gynaecologist of many years standing. Hence, using the *Bolam* test, as modified by *Bolitho*, we find that the treatment and care of the second plaintiff during the delivery of the baby was well within 'practice accepted as proper by a responsible body of medical men skilled in that particular art'. Thus, we find that there is no breach of the standard care by the first defendant. In the premise, the learned trial judge's finding to the contrary is, with respect, plainly wrong.

[94] There was an issue raised by the plaintiffs' counsel as to the whether the first defendant had a lack of experience in shoulder dystocia cases, and whether the second plaintiff ought to have been informed of such deficiency in experience. When the first defendant was cross-examined by the second defendant's counsel, the following exchange took place:

> Q: You have the head out but can't tell the shoulder ...?
>
> A: Because when the baby rotates, the baby faces the thigh of the mother. Her baby did not face the thigh of the mother, the baby was looking down.
>
> Q: Have you faced many similar position?
>
> A: I hope never to face it again.

[95] The learned trial judge took this exchange to mean that:

> ... D1 had a duty to inform Mdm Baljeet that she had limited experience of managing shoulder dystocia complications during delivery ...

However, the evidence showed that the first defendant does have experience dealing with shoulder dystocia cases. The type of shoulder dystocia of baby GTK, where the head was facing down instead to her mother's thigh, was something that the first defendant had not encountered before, and hoped never to encounter. And as such the finding by the learned High Court judge that the first defendant had 'limited experience of managing shoulder dystocia complication during delivery' is unfounded. In any event, shoulder dystocia is known to occur even in delivery of babies who are not macrosomic. During the antenatal visits, there was no indication that the second plaintiff's baby would encounter shoulder dystocia for that topic to have been specifically dealt with by the first defendant, and the second plaintiff be apprised of the first defendant's experience in handling shoulder dystocia cases.

Sixth issue — Were the second plaintiff's injuries to her perineum sufficiently identified, treated and managed?

[96] Nurse Ng, who assisted in the delivery of baby GTK, had recorded in her notes that the second plaintiff had a second degree vaginal tear, whereas the first defendant had noted the injury as a 'small fourchette tear' and 'only a small

vaginal tear, which was sutured in 2 layers'. However, when cross-examined Nurse Ng said that she put it down as a second degree tear merely based on her observation and not by proper physical examination of the second plaintiff. She confirmed that to ascertain the nature of the vaginal tear, a physical examination by inserting the finger and then slowly parting the vaginal tear would be necessary to ascertain the degree of the tear. In this case, she said that she did not carry out the physical examination.

[97] However, in contrast to that, the first defendant actually examined the tear and categorised it as a small vaginal tear, which she sutured. Further, after the second plaintiff's delivery of the baby, as the first defendant was on leave, another obstetrician and gynaecologist, Dr Kamaljit (DW3) practicing in Pantai Hospital, who stood in for the first defendant had examined the second plaintiff and found her fit and proper to be discharged. Dr Kamaljit in her testimony said:

> ... the uterus was 16 weeks size, well contracted, lochia was normal and the *perineum was clean*. I also noted there were second degree hemorrhoids which were much better after Daflon, after speaking to the patient.

[98] When further questioned on this Dr Kamaljit explained:

> Q: Now, when you say the perineum was clean. We have heard before this Court the definition of perineum. In your mind, what is the meaning of perineum?
>
> A: The area from the mons pubis right up to the buttocks, which would be the anal area which consists of labia, the vagina right up to the anus, in this case, in this context.
>
> Q: And it was clean?
>
> A: Clean in the sense that there was no redness and there was no pus and there was no active bleeding. There was lochia though, lochia which would be normal for a person who just delivered vaginally or by C-section, in any case. So post-delivery, lochia would be normal.
>
> Q: At the discharge, did you give her any advice?
>
> A: ... In any case the nurses don't call her, she has the clinic number and she is still able to call the clinic in case she needs assistance. Although Dr Premitha is away, we could troubleshoot in the sense that I could cover in case she needs any assistance.

[99] Despite this when cross-examined on the subject of her injuries and the pain from the injury to her perineum post discharge, the second plaintiff had offered the following testimony:

> Q: So even though you were in pain and bleeding, you refused to tell Dr Premitha's nurse 2 weeks after your discharge that you were in pain and bleeding?

A: Yes ... because Dr Kamaljit told me it's the natural course of recovery, I was doing well.

Q: But you know about the follow-up that you have to come back in 6 weeks?

A: Dr Premitha's nurse called me I think 2 weeks later after I had the baby to come in for a check-up.

Q: At that time Madam, did you tell the nurses about the pain and the bleeding that you were going through?

A: No ... because I had lost complete trust in the doctor and the care the hospital provided.

Q: The foul smell came because 2 weeks after you were discharged, you already received a call from Dr Premitha's clinic and they already asked you to come back, which you failed to Madam?

A: Because I no longer had trust in the doctor and she gave me ample medication for that whole month.

[100] The second plaintiff having had lost trust and confidence in the care given by the first defendant, went to see Datin Dr Hu Shan (PW2) in another hospital for her further post-natal follow-up. Dr Hu Shan saw Mdm Baljeet after a history of five and a half weeks of vulva and perineum pain. Dr Hu Shan found on pelvic inspection, there was a 2cm hole at her perineum and on examination under general anesthetic found: (i) a midline poorly healed scar close to the anus; (ii) second degree perineum muscle defect 1.5cm width and 2cm long hole in the perineum muscle; (iii) first degree high vagina tear, where active bleeding was seen; and (iv) Nabothian abscess and cervicitis.

Dr Hu testified that:

When check on the perineum, the hygiene was not there, so I asked her to maintain the cleanliness. So its frequent changing of pads and also cleaning up and washing up.

This testimony was similar to that of Ms Elizabeth Pithchaimuthu (SD6), the lactation consultant, who had visited the second plaintiff post-delivery. She testified that:

And when I checked her perineum, I did ask her to maintain hygiene because there was a bit smelly ...

Now, the second plaintiff's injury to her perineum was first attended to by the first defendant who had sutured the tear. The second plaintiff was then seen by Dr Kamaljit at Pantai Hospital who had examined her before discharge. There was no indication that there was anything wrong with the treatment that the second plaintiff had received from the first defendant for the injury to her

perineum. The foul smell that came from that area some weeks later has been attributed by Dr Hu, as well as the lactation consultation, to the second plaintiff's failure to maintain proper standards of hygiene. Dr Hu also confirmed that wound breakdown is very common where hygiene is an issue. Therefore, we find that to attribute blame unto the first defendant for these wound is flawed, as the causal link between the care and treatment given by the first defendant up to the point when the second plaintiff was discharged and the injury complained of much later had not been established. We find that there is insufficient evidence showing that the second plaintiff's post-delivery injuries had been sufficiently identified, treated and managed by the first defendant. The evidence showed that it was more probable than not that the injuries identified and treated by Dr Hu Shan were exacerbated by the second plaintiff's poor hygiene in the affected parts, coupled with her indifference to seek treatment immediately when she was in pain and bleeding some two weeks after delivery, and not because of the first defendant's failure to properly identify and treat the injuries.

Seventh issue: Quantum of damages

[101] We are of the view that since the finding of liability against the first defendant is wrong in law and ought to be set aside, the issue as regards the quantum of damages need not be addressed by us. In any event, even if the finding of liability were to stand, we find that the damages assessed and awarded by the learned High Court judge were fair and reasonable. However, as we have allowed the first defendant's appeal against both liability and damages, we also set aside the damages awarded.

Eigth issue: The dismissal of the plaintiffs' case against the second defendant

[102] Corollary to our finding that the first defendant was not negligent in her care of the plaintiffs, nor that she had breached her duty of care towards the plaintiffs, we are constrained to rule that the claim against the second defendant cannot be sustained.

CONCLUSION

[103] We had earlier alluded to the duty and function of an appellate court and in that regard, we are once again reminded of the valuable advice of Lord Pearce in his dissenting speech in *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyds Report 403 at p 430; which was referred to with approval by this court in *Sivalingam a/l Periasamy v Periasamy & Anor* [1995] 3 MLJ 395; [1996] 4 CLJ 545:

> The function of a Court of Appeal is to set aside a judgment that should not be allowed to stand because it occasions a substantial wrong or a miscarriage of justice.

> That wrong or miscarriage of justice may consist of a judgment in favour of the wrong party. It may also consist of a failure in the judicial process to which both parties are entitled as of right, namely, the weighing of their respective cases and contentions. Such failure may constitute a wrong or miscarriage of justice even though it may appear that the appellant may in the end fail to secure a judgment in his favour: But the fact that the right party seems to have succeeded in the court below will naturally make a Court of Appeal extremely reluctant to interfere, and it would only do so in the rarest cases. Such matters are questions of degree.

See also *Len Min Kong v United Malayan Banking Corp Bhd and another appeal* [1998] 2 MLJ 478; [1998] 2 CLJ 879, and *Majlis Perbandaran Seremban v Era Baru Sdn Bhd and another appeal* [2018] MLJU 706; [2018] 1 LNS 829. We find that the learned trial judge had completely overlooked the inherent probabilities of the case in entering judgment for the plaintiffs. We are fully conscious that this is an appeal that turns primarily upon the findings on questions of fact, and we ought to be slow in disturbing such findings except in circumstances where intervention is warranted. In the present case, for reasons discussed earlier, we find that appellate intervention is necessary. A careful perusal of the learned trial judge's grounds of judgment shows that the process of reasoning adopted by her for preferring the evidence of the plaintiffs' witnesses is based upon wrong premise and does not accord with well-established principle that goes to form the fulcrum upon which the scales of justice turn. The conclusion drawn by the learned trial judge also goes against the grain of evidence. We are under a duty to intervene in a case where, as here, the trial court has so fundamentally misdirected itself, that one may safely say that no reasonable court which had properly directed itself and asked the correct questions would have arrived at the same conclusion.

[104] Hence, we allowed the first appeal, ie Civil Appeal No W-02(NCVC)(W)-2006–11 of 2019, by the first defendant against the entirety of the High Court's judgment, ie both in respect of liability and quantum against the first defendant, and the High Court order in respect of liability and quantum against the first defendant is set aside. And we dismissed the second appeal, ie Civil Appeal No W-02(NCVC)(W)-2018–11 of 2019, by the first and second plaintiffs.

[105] Costs here and below was fixed at RM160,000 to be borne and paid by the plaintiffs/respondents to the first defendant/appellant in respect of the first appeal. Costs of the second appeal in the sum of RM20,000 to the first respondent and RM30,000 to the second respondent to be borne and paid by the appellants/plaintiffs. All costs are subject to allocator.

Orders accordingly.

Appeal No 2006 allowed; Appeal No 2018 dismissed; and High Court's decision set aside.

Reported by Ashok Kumar